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*Dept*  
*from the Office of the Minister of National Health and Welfare*

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Statement by  
HONOURABLE ALLAN J. MacEACHEN  
on the  
RESOLUTION TO PROVIDE FOR A  
GUARANTEED INCOME SUPPLEMENT

THE HONOURABLE ALLAN J. MacEACHEN, MINISTER



In this resolution, Parliament is being asked to consider a program which guarantees old age security recipients an income of \$1260 a year or \$105 a month. Approximately 900,000 senior citizens now on modest incomes will benefit from this program in 1967. This number will increase over the next few years as the age for old age security is lowered from 68 to 65. The program will cost Canadian taxpayers between 260 and 280 million dollars in 1967.

I know one main concern of members is with the method of determining levels of benefits available under this program.

Some persons have attempted to attach a means test label to the program while others have talked about a needs test. Because it involves the provision of a guarantee of a basic minimum income, it is necessary that a norm of eligibility be employed. There is no other way to administer or operate a guaranteed income program of this kind.

But I can assure members that the norm is, in my view, a simple and acceptable one. It does not involve what we commonly refer to as a test of means or needs.

I hope that members will resist the temptation to get partisan mileage out of the proposal on this round; that no attempt either intentionally or inadvertently will be made to spread the spectre of a means test among our older people. I repeat: the norm envisioned





under this program is a far, far cry from the means test. I am confident that when the guaranteed income supplement is in operation, a majority, if not all, the eligible older people of Canada will agree with this assessment.

The purpose of this program is to provide maximum assistance to those on modest incomes; I suggest that the contemporary guaranteed income approach is the most effective and most responsible way of achieving this objective.

Lest I be accused of hair-splitting or of indulging in semantics, I would examine for a few minutes what is involved in tests of means and needs.

A means test means just that. It involves an examination of the nooks and crannies of a person's financial status: the money he has in the bank, whether he owns a car or a home, the ability of relatives to contribute to his support, his earnings and so on.

Under a needs test, the other side of the ledger is examined. Its purpose is to determine the gap between what a person has and what he needs for an adequate, decent existence and to base benefits on the difference. Under a needs test, income is also taken into account but the emphasis is on meeting needs on a flexible basis.

The program proposed in this resolution is based on neither of these approaches. The criterion is a





universal guaranteed income, a floor below which an individual's income will not fall. The objective is to provide a flow of income and the definition or determination of an individual's flow of income is identical with that used for income tax purposes. This is a simple, acceptable and effective way of determining eligibility and calculating levels of benefits.

No information will be asked for that is not already required for income tax purposes; there will be no snooping, no prying into financial affairs, no demeaning questions.

This program is an innovation, the application of a contemporary technique to what has been a continuing problem in modern, industrialized society -- the provision of adequate income to people who, because of age, are not able to earn on their own.

Members are aware, I am sure, of the current public interest in the guaranteed income technique. It has come in for considerable public discussion and there have been suggestions that the approach be applied on a broader basis. Many believe that the guaranteed income mechanism provides the best hope for adequate income maintenance in an era where more and more jobs involving human labour are being turned over to machines.



The program applies this new technique in a limited and specific area. It is, I suggest, an area where the chances of success are encouraging because it does not involve some of the difficulties which might be associated with a guaranteed income applied to all the population.

First, a great majority of the people included in this program are, or will be, retired and there will consequently be no material interference with incentives to work.

Also, of course, the program is designed for a specific, identifiable group and this should make for relatively easy administration.

Members will ask, and indeed, have asked: Why this approach? Why not a flat rate increase in the universal pension? Opposition parties have suggested \$100 a month.

As a short range political project there is no doubt but that to be on the side of an across-the-board \$25 monthly increase is to be on the side of the orthodoxy, easy administration and simple amendments to the existing statute.

But, any analysis based on long-term considerations supports the guaranteed income approach on two important counts: First, it provides more help to those on modest incomes -- it guarantees a monthly income of at least \$105





a month, not \$100 -- and second, it is a more effective and responsible deployment of the federal government's financial resources.

There are those who argue that the flat rate increase will provide an extra \$25 a month to all. This, of course, is not true. Under our income tax set up, some older persons are required to pay back a portion of what they receive. The guaranteed income format, is steeply progressive and concentrates on added payments for those on modest incomes.

Estimates in the current year are that the guaranteed income supplement will cost between \$260 million and \$280 million in its first year. Take the median figure of \$270 million; this is \$100 million less than the cost of a \$25 a month increase in the flat rate pension. The cost of the flat rate pension, of course, would increase annually so that by 1970 it would amount to something in the neighborhood of \$200 million a year more than the guaranteed income supplement.

In the long run, costs under the income supplement program will decline as more and more people become eligible for higher and higher benefits under the Canada and Quebec Pension plans. Any simple increase to \$100 a month, on the other hand, is a commitment in perpetuity.

The guaranteed income supplement is meant to meet the income requirements of a specific group of people -- those





who because of age cannot benefit or benefit only in part, from the Canada and Quebec Pension Plans. The need to meet such income requirements will diminish as these plans become fully operational.

I would also note that the Canada and Quebec Pension Plans were devised with the \$75 a month universal pension in mind; it would provide a basic retirement income to which contributory pension benefits would be added to provide a decent and adequate income level for persons when they retire.

When the Canada and Quebec Pension plans were introduced, the retirement benefits were set at levels which, combined with those available under old age security, were designed to provide a satisfactory retirement income for most Canadians. At low income levels, the combined benefits exceed previous earnings while for those earning \$5,000 or more a year, the monthly benefit will be \$179. These combined benefits compare favorably with those available in other countries.

The Canada and Quebec Pension plans, of course, are of little benefit to those who, through no fault of their own, are unable to get any or full benefits because of age. For this reason, we are bringing forward this guaranteed income supplement.

The new program uses the Old Age Security and Income Tax Acts as its legal and administrative base. This



concept of an income guarantee plan was embodied in the recommendation of the Special Committee of the Senate on Aging. In determining the amount of the guaranteed income, sources of income other than the supplement are taken into account. Income for this program only includes, of course, those items regarded as income for the purposes of the Income Tax Act. For example, money drawn from savings or received from the sale of a home, other possessions or investments, are not considered income. Gifts and donations received by pensioners are also disregarded in calculating the pensioners' income. Also, social assistance payments from municipal, provincial and federal governments are not considered as income. In using the income tax definition of income, awards for loss of life or loss of function because of disability, whether paid in lump sum or continuing payments, are excluded as income; this relates to awards under commercial insurance plans, workmen's compensation and war pensions. On the other hand, income from the basic flat rate old age security pension and from other pension plans, including the Canada Pension Plan, are counted as income.

I would like to elaborate on some of the points I have already mentioned.

Under the present old age security legislation a portion of income from the pension is taxed back through personal income tax. At very high levels of income the





proportion taxed back is considerable, while at low income levels nothing is recovered through personal income tax. For those people with incomes somewhere in between, the degree of recovery varies.

Under this program, recipients of old age security who have no other income, of the type considered to be income under the income tax act, will receive the full amount of the supplement -- an additional \$360 a year. For those who have other income there is provision for partial supplements, ranging up to the full supplement of \$360 a year. This is available to single pensioners who have an annual income, including the flat rate pension, of less than \$1620 and to married pensioners who have a combined income of less than \$3240 annually.

Thus, the income supplement redistributes income in favour of single persons and married couples with incomes of below \$1620 and \$3240 respectively, rather than over the whole range of incomes as is the case under the existing old age security pension.

The program ensures a guaranteed income floor whereby no person who is receiving an old age pension will get less than \$1260 a year and no married couples, who are receiving pensions will get less than \$2520 a year. The full or maximum income supplement is expressed as 40 per cent of the basic old age security pension. By making the



supplement a percentage of the \$75 a month pension, the supplement will automatically be escalated by any changes in the basic flat rate pension arising from changes in the cost of living as reflected in the Pension Index.

For those who do not qualify for the full or maximum supplement of \$360 a year, but who are entitled to a partial supplement, a simple rule applies with respect to the amount of their benefit. The annual supplement of \$360 is reduced by one half of the amount of income in excess of the \$900 a year old age security pension. Expressed in another way, the amount of the supplement will be reduced \$1 a month for every \$2 a month that income increases over and above the flat rate \$75 a month pension.

This is a different approach than the sharp cut-off implied in the proposal of the Senate Committee, which eliminated one dollar of supplement for each dollar of income above the \$75 old age security pension.

In the program now under consideration we had originally planned to follow that approach and had estimated the cost at about \$225 million. However, we have decided to make provision for tapering off the supplement. This approach is more equitable for people with modest incomes from small pensions and part time employment. It is likely as well to be more acceptable. It is, of course, more costly and as a result the cost of the program in 1967 will be between \$260 and \$280 million as I have already mentioned.





Perhaps I can illustrate the partial supplement with two examples.

If an old age security recipient has a small private pension of \$120 a year as his only income other than old age security, the maximum supplement of \$360 is reduced by one half of the \$120, leaving a partial supplement of \$300. In this example, the pensioner would have a total income of \$1320, consisting of \$900 basic pension, \$300 income supplement and \$120 from the private pension.

Another example would be a recipient who has a part time job from which he receives \$360 a year. He would receive an income supplement of \$180 which along with the \$900 basic pension would bring his annual income to \$1440.

The Senate Committee suggested a guaranteed income of \$2,220 for a married couple. We are proposing a higher level of guaranteed income. Pensioners will receive supplements which will guarantee an income of \$2520 for the couple, if both are eligible for old age security. This will mean a maximum supplement of \$360 a year for each spouse or a total of \$720 for the couple. In addition, partial supplements will be provided for those who have income over and above their old age security pension, but who have a combined total income, including basic pension of less than \$3240.

The approach inherent in the Senate Committee's proposal of using the combined income of the couple rather than individual incomes has been followed. This gives more



equitable treatment between single persons and married couples, since it takes into account the full income of a married couple.

Under the proposed legislation the income of each spouse is taken to be one-half of the combined income of the couple in determining the amount of each spouse's supplement. Thus, each spouse receives the same amount of supplement.

Each old age security beneficiary entitled to an income supplement will receive one monthly cheque combining the basic flat rate pension with the supplement. In the case of married recipients, each spouse will receive a cheque, as is the practice under old age security at the present time. For persons receiving the flat rate old age security pension, the guaranteed income supplement and the Canada Pension Plan, one cheque for the combined amount will be sent each month.

As I mentioned earlier, the proposed program is transitional in nature. In this regard it endeavours to take a second step in meeting the recommendation of the Joint Committee of the House of Commons and Senate on the Canada Pension Plan which recommended "further measures regarding the position of those people who, because they are or soon will be retired, will not be substantial contributors to, or beneficiaries from the Canada Pension Plan".





The first step in endeavouring to improve the income support for this sector of our population was taken last year through the amendment to the Old Age Security Act, under which provision has been made for the lowering of the age of eligibility from 70 to 65. Through this amendment all persons 69 years of age are now on pension, within a few weeks those age 68 will qualify for pension, and by 1970 all persons 65 years of age will be covered. By that time more than half a million persons who either could not participate at all or only to a limited extent in the Canada and Quebec Pension Plans will receive these old age security payments.

The initial cost of this amendment has been considerable and each year as a new age group is added there is a substantial impact on total annual costs. In 1967, the additional expenditure will be \$190 million; in 1970 when the full effect of this amendment will be felt the additional expenditure for this improvement alone will be \$568 million in that year.

We now have before us a further extension of the old age security program to add substantial income support for this group. In 1962 and again in 1963 the old age security pension was raised, bringing the rate from \$55 to \$75 a month. Under this proposal the rate will be raised to a maximum of \$105 a month.



In 1967, outlays under the existing old age security pension will reach \$1,110 million; the additional cost of the guaranteed income supplement could reach the order of \$250 to \$280 million, making a total expenditure of about \$1.4 billion. In 1970, the total expenditures under the old age security program will reach about \$2 billion; of this amount expenditures under the guaranteed income supplement will be in the neighbourhood of \$385 million.

It is proposed that the payments for this income supplement will be financed from the old age security fund. The tax measures required in connection with these expenditures will be dealt with by the Minister of Finance in his Budget in the very near future.

It is proposed that the guaranteed income supplement program take effect in January 1967. The initiation of the program will, of course, be a large administrative undertaking. Early in the new year application forms will be sent to all recipients of old age security. Those who qualify will receive monthly supplements retroactive to the month of January. Supplementary payment will be combined with the old age security cheque and we expect that the first cheques including the retroactive supplementary income payments will be sent out with the March old age security cheques. We would hope to have all these retroactive payments connected with the introduction of the program cleared up with the April cheque mailings.





Pensioners eligible for the maximum income supplement who have had their application submitted and approved by the end of February would receive a payment of \$165 in March. This would consist of the \$30 supplement for January, February and March and the \$75 basic pension for March. For those who qualify for the maximum supplement and who receive their first supplement in April, the first payment would be \$195. In subsequent months, when the backlog involved in initiating the program will have been cleared away, those receiving the maximum benefits -- old age security plus the income supplement -- will be getting a cheque of \$105 a month.

A simplified application form has been designed for the program. It was considered that this would be easier than the normal income tax return for many old age security recipients to complete. The statement of income on the application form requested in January 1967 will be the pensioner's income for the past year, that is for 1966. For the great majority of pensioners their income is relatively stable from one year to the next and they knew with considerable accuracy what income they had in the past year. Because of this, it is not anticipated that this procedure will be difficult.

For those who need some assistance in completing the application, relatives and friends will assist them as they do now for old age security applications and for income tax returns. The staff in Old Age Security, Canada Pension Plan and Income Tax offices will be available as they are now to help in answering questions and to deal with any special situations.



In some instances the pensioner may wish to revise his initial statement of income because of more detailed information obtained later. If this is done an adjustment of the supplement will be made to take into account this change. Information supplied on income can be checked against income tax returns and third party information supplied to the Department of National Revenue on T-3, T-4 and T-5 and other returns.

For the small group of pensioners who retired in 1966, the earnings for that year would not be representative of their income status in 1967. To prevent hardship for the pensioner who had retired in the year before he applied for the supplement, he will be allowed to exercise an option.

Under this option he can disregard his earnings in 1966 from the employment or business from which he retired along with any pension income for that year and substitute for them an estimate of his income from pensions, employment and any business in 1967. Thus if he has no employment or business income but only his pension income in 1967, he would likely be better off to take this option.

Each year there will also be a group of pensioners who will retire from their employment or their businesses but who would qualify for supplements on a partial year basis. An option will be provided for them whereby they can use estimated income for the current year rather than past years' income and ignore earnings from employment or business from which they have retired and have pension income counted only for the part of the year remaining after their retirement.



Some pensioners, although otherwise entitled to the guaranteed income supplement, may be temporarily out of the country for health reasons or to visit their children living abroad. It would seem fair to continue to pay the supplement to qualified pensioners for a reasonable period of absence from Canada. It is proposed that the supplement be paid in all cases for the month when the pensioner leaves Canada, and for a maximum of an additional six consecutive months. Payments would be resumed with the month when the pensioner returns to Canada. For those that remain permanently outside of Canada in many different countries in many parts of the world it would not be feasible for us to verify their statements of income in order to administer the guaranteed income supplement. For this reason no provision has been made to cover those who leave Canada permanently.

The Guaranteed Income Supplement will be administered by the Old Age Security Administration of the Department of National Health and Welfare. The Income Tax Division of the Department of National Revenue will assist by matching information on statements of income received by National Health and Welfare against information obtained through income tax sources. Provision is made under the legislation for appeals against decisions or determinations made with respect to eligibility for and the amount of income supplement and basic pension payments.





In undertaking this program and in drafting the necessary legislation for it, the Government has of course fully taken into account the constitutional authority of the federal Parliament as it relates to old age pensions. The Government is not in any doubt about the validity of the present old age security act, or parliament's authority to enact the amending bill to follow this resolution.

We believe that the proposals which we will be placing before the House at the conclusion of this debate represent a conscientious and constructive attempt to meet the income problems of Canada's older people in a way which conforms closely to contemporary concepts of social justice. This program, we feel will concentrate additional income where the need is most pressing -- in the low and modest income areas. In this way, it achieves a realistic and equitable balance between the financial responsibilities of the federal government and its obligations towards those older people who have made such a substantial contribution to the nation's progress and prosperity.

With these thoughts in mind, I would commend this resolution for the approval of honourable members.

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*from the Office of the Minister of National Health and Welfare*

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Notes for an address by

HONOURABLE ALLAN J. MacEACHEN, M.P.

MINISTER OF NATIONAL HEALTH AND WELFARE

TO THE ANNUAL MEETING OF THE CANADIAN UNION OF STUDENTS

DALHOUSIE UNIVERSITY, HALIFAX, N. S.

September 3, 1966.

THE HONOURABLE ALLAN J. MacEACHEN, MINISTER





When I accepted the invitation to join you today it was on the assumption that I would have several weeks of tranquillity to prepare; weeks in which I would have time to contemplate and sort out those wise words and profundities which we elders -- and more particularly, we politicians -- are said to have tucked away against occasions such as this.

You will know by now, how naïve and nebulous this assumption was.

Nevertheless, I am pleased to be here and to get away, if only for a few hours, from the climate of Parliamentary politics. I will not be naïve again and suggest that by being here, I am escaping government critics. I am very much aware of the interest which the Canadian Union of Students has taken in activities of the federal government -- from the Student Loans program to the Company of Young Canadians -- and I realize full well that you have not hesitated to criticise and condemn some of our proposals and programs. Indeed, if any federal politician is unaware of your views on such matters, it is certainly not the fault of CUS and its executive.

But I know, too, that the criticisms and suggestions you put forward are constructive ones and are based, not on partisan considerations, but on a sincere desire to see that problems affecting students and higher education generally are settled properly and justly. And I am sure that even though you may not always agree with what we do, you will give us the same benefit -- that you will believe that our decisions, and



some of them are very difficult ones, indeed, are taken with the best of motives and in an honest attempt to equitably balance the responsibilities which a government has towards its public -- university students as well as senior citizens, taxpayers as well as the poor and the poverty stricken.

Such motives are not always conceded in politics and perhaps under our party system it is not possible or even desirable that they should be. Perhaps it is inevitable that a government, and particularly a government in a minority situation, should expect criticism and condemnation, no matter what decisions it makes or does not make. Where there are several alternatives, and there usually are, a government can expect criticism no matter which it chooses.

Someone has said that a minority government is in much the same position as a wife with a grouchy husband. On one particular morning, this husband came down to breakfast in an especially surly mood. "What will you have, dear?" his wife asked.

"Two eggs," he snapped, "one fried, one scrambled."

Shortly, she put a plate in front of him, bearing the fried egg.

"Great Days!" he snarled. "Can't you ever do anything right? You fried the wrong egg."



Perhaps this is an exaggeration and I readily concede that any government worth its salt is going to have to become embroiled in controversy and unpopular decisions. To do otherwise is to abdicate the responsibilities of government.

When we analyse and assess the decisions and direction of government, we must do it against a contemporary background. We are living in an age of social -- and even moral -- unrest, when old values are being challenged on all sides and new ones being embraced with widespread enthusiasm. But there are still many who unquestioningly adhere to the old values and even though the new -- whether it be the new morality or the new technology or the new social order -- may be perfectly acceptable to you, don't forget there are many others to whom these new manifestations are an anathema or, at least, intolerable and threatening enemies.

We live in an age of social strain and the product is fragmentation -- along geographical, cultural and intellectual lines. It is a curious commentary on our time that while we appear to be making progress -- in fact as well as in theory -- in such areas as racial tolerance and ecumenism -- we are heading for more and wider chasms in other areas. Our own country is peppered with strong regional and provincial interest groups, there appears to be a growing breach between the thinking of urban and rural dwellers and the age-old gulf between the views of youth and those of their elders is in strong evidence.





This is not necessarily a bad thing and if we can work out common values and ideals in such areas as religion and racial relations, the clash of ideas and ideologies in other fields can have a worthwhile impact -- providing it is tempered with tolerance and patience.

In Canada, the intellectual foment and social upheaval will eventually work itself out and that an identifiable Canadian consensus will emerge. But until this day comes, we need leadership which can detect and assess the different and often conflicting pressures and who can see us through these troubled and unsettled times. Without such leaders, we run the risk of producing administrations that may unduly reflect one or other of the many currents of thought afloat in the country and further aggravate the division and dissension.

Canada, of course, is not the only nation going through a period of unrest and social and intellectual upheaval; nor is politics the only activity in which these phenomena manifest themselves. Some of these other nations have strong majority governments, some even, are under the rule of strong totalitarian regimes. Yet they have not fared any better, or as well as Canada.

President Johnson, for example, is a person of remarkable versatility, a man elected to the presidency with one of the most massive mandates in U.S. history. Yet he is being buffeted by public opinion and his country faces some pretty grave and complicated problems.



Certainly no political pundit would call Prime Minister Wilson a weak leader. He, too, commands a strong majority in his Parliament yet he, too, is beset by mounting problems within his country and even within his own party.

Even in such totalitarian nations as Communist China there is foment, and disenchantment at the political level and a consensus -- if so it can be called -- is maintained only through the most draconic measures.

There are, undoubtedly, traces of this same world-wide nervousness in the current labour unrest, in the growing strains between union membership and leadership, in the divisions and debates within political parties and professional groups. In the student movement, the theme of your Seminar this week at Waterloo -- Identity and Anxiety -- is perhaps the best indication that you, too, are searching and worrying.

But my purpose is not to lecture you on social mores or political philosophies; you will have your fill of these, as classes resume in the next few weeks.

Mr. President, I have read with great interest and, I should add, considerable approval, the papers which have been prepared for this meeting and your Seminar in Waterloo.

These papers cover a wide range of issues, both domestic and international, but it is perhaps natural that they should be particularly concerned with the question of higher education.





I, too, would like to make a few observations on this vital question. For the most part, they will be personal observations, more in the nature of food for thought rather than a blueprint of what the federal government may or should or will do.

But before I do this, I should tell you that the present federal government, in its three and one-half years in office, has taken several steps to assist and encourage higher education in Canada. As students, I am sure you are aware of these steps -- the \$10 a month youth allowances program, the student loan plan -- the proposed \$3 increase, from \$2 to \$5, in the per capita grants to universities, the proposed \$40 million bursary-scholarship plan and the \$500 million Health Resources Fund.

Some of these are measures which CUS has long advocated and I am aware, as well, that you have urged additional programs and have recommended improvements and changes in some that have been put forward. I can assure you that your views are being given every consideration and, I am sure, will be taken into account when the federal government and the provinces meet to discuss the problems of financing higher education.

I can assure you, as well, that the government of which I am a member is, in the words of the Prime Minister, committed to ensuring "that all young Canadians of outstanding ability -- have the higher education that will enable them to use their talents to their own and their country's advantage."



The Prime Minister went on to say that "there should be equality of opportunity for such people, whatever the financial resources of their parents and wherever in Canada they live".

The programs so far produced and proposed by the federal government will, I think, help reach this objective.

But they are not the final and complete answer, nor are they meant to be. As I said, we will be having a federal-provincial conference to examine other approaches and re-examine existing ones. The federal government and the provinces will come to this meeting with a common objective -- to ensure that every Canadian capable of benefitting from higher education is able to get it. And for the federal government, there is an added concern -- how to carry out its role in a field in which it has substantial and unquestioned national obligations but in which the prime constitutional jurisdiction rests with ten other governments.

In the field of student aid the limit of federal concern is to ensure a basic measure of equal opportunity for academically competent young men and women throughout Canada.

Although, as I said, there is unanimity on this objective, there is no consensus, either among the public generally, or in academic circles, as to how this objective can be most effectively achieved.



This division of opinion is reflected both in the submissions to the Bladen Commission on Higher Education and in the report of the Commission itself. Some submissions argued strenuously and eloquently for free tuition; others went further still and advocated free education -- including a living allowance for students. Even with the student movement there was a lack of unanimity -- some student groups argued for the continuance of fees while others suggested fairly substantial increases.

The only consensus which the Commission was able to report was on the general principle that "no qualified student should be prevented by lack of means from embarking on and completing his education and that there must be a greater commitment from public funds to achieve this objective".

The Commission, as you know, saw merit in both sides of the tuition-abolition question and chose a middle ground where costs would be divided between the individual and the state. It, too, concluded that "access to higher education should not be denied by reason of financial difficulty to any who are intellectually qualified". In essence, it recommended continued tuition payments for those who can afford them and more generous aid to those who cannot.

This is the approach which has been adopted generally in western democracies and certainly it is a practical one in terms of government expenditures. But is it the only or the





most effective alternative? Are the arguments against complete abolition of tuition fees -- that it will only further increase the imbalance in favour of well-to-do students -- whose background and environment are more inclined to inspire ambition for a university education -- that it will destroy initiative and impose an unfair tax burden on wage earners who chose not to go to university -- all that valid? Or are they essentially the same arguments, perhaps clothed in different language, used when free, universal elementary education was in the process of being introduced?

Too often, the people who are "adequately qualified" to attend college or university are those from well-to-do families.

There is ample evidence that this is so. A recent study of higher education in the Atlantic provinces, for example, concluded that:

"There is no doubt that in all four provinces many students who should go on to higher education fail to do so, and there is a serious loss of student potential. One might say, by way of a broad generalization, that only about half of the potential seems to be realized."

The reasons given for not realizing this potential were, in order of importance: lack of money, students are not attracted to further council -- guidance and counselling, I suppose, would be involved here -- and insufficient



matriculation requirements. The outcome seems to be that these persons are academically able but are uncertain where their aptitudes and interests lie. They need opportunity to discover these without committing themselves to the high financial and temporal costs of attending university.

Still, the fundamental barrier is a financial one and the question is whether in a society which increasingly demands that its members be technically-skilled and/or university trained, we can continue to differentiate in public policy towards various levels of education. Various studies have indicated that by 1970 anyone with less than a Grade XII education will have extreme difficulty finding a satisfying and self-supporting niche in the labour market and that, by the same token, the economic pendulum will swing even more heavily in favour of the technically-skilled and university trained.

This being so, can we continue providing "free education" in that segment of the educational system which only lays the basic foundation for a modern career, while maintaining the financial barriers in the higher educational levels from which an increasingly greater percentage of our work force must come?

The program proposed by Professor Bladen -- requiring payments from those who can afford it, more aid for those who can't -- is, a starting point. But, I would add, it



is becoming increasingly obvious that governments -- provincial and federal -- must sit down with the universities and map out a master plan for higher education in Canada, including the question of abolishing tuition fees. And, while the constitutional realities are obvious and must be respected it should still be possible to put the interests of education first.

Personally, I am not at all convinced that the arguments against the removal of tuition fees are all that valid. I agree, and I'm sure most of you can attest to this from personal experience, that the financial difficulties involved in obtaining a university degree, make the prize all the more precious for those of you who are familiar with the writings of the late Sidney Smith will also know that there is a great deal of mythology surrounding the so-called benefits of working one's way through college. It involves a lot of heartbreak, discouragement and disappointment; cutting corners on studies, interrupted careers; and how many, with the urge and brains but not the cash, have had to cut short their studies after one or two years?

I realize that tuition fees are only a part of the cost of a university education and their removal would still leave substantial financial hurdles for the aspiring graduate. But looking beyond the Bladen report, I suggest the next step could be the removal of tuition fees which would leave student aid programs to concentrate on those other financial areas





which deter or discourage capable young men and women from seeking higher education. The countries of the western world are moving closer and closer to the ideal of a university education, open to all who can benefit and I would hope that Canada will be among the leaders in this reform.

And, just as the abolition of tuition fees is not the magical "open sesame" that will throw wide the doors of Canadian universities to all, neither can we ensure equality of educational opportunity by looking only towards the university or by concentrating on the educational sphere.

It is ridiculous to talk seriously about "universal accessibility" without considering such things as the war on poverty, medicare, the Canada Assistance Plan. These problems must be approached with the total environment in mind; they cannot be solved at the university level alone.

If our young men and women are to enjoy equal opportunity to exploit fully their talents and skills, we're not going to do it simply by removing the financial barriers at the gates of the university and other institutions of higher learning. It will mean changes and reforms at the elementary and secondary school levels, more and better guidance and counselling, eradication of those pockets of poverty which destroy initiative and all too often destroy, almost at birth, the motivation and spiritual awareness without which few, if any, can ever develop their full intellectual potential.



There is another thought I would like to leave with you, a note of caution, if you like. It is that "universal accessibility" does not mean that everyone will, or indeed should, go to college. I'm not in favour of university education because for some it has appeal as a status symbol.

We have had, and no doubt will continue to have, a good deal of argument about the quality of education in this country. I suggest that many of these arguments are pointless and, I might add, too often they degenerate into arguments over "elite" and "mass" education. People who engage in these arguments are like the two washerwomen Sydney Smith observed leaning out of their back windows and quarrelling with each other across the alley.

"They could never agree," Smith said, "because they were arguing from different premises."

In the case of arguments over "elite" versus "mass" education, both premises should be abandoned, because behind the argument is the assumption that a society has the choice of either educating a few people exceedingly well or educating a great number of people rather badly.

This is a straw-horse dilemma. It is possible to have excellence in education and at the same time to seek to educate everyone to the limit of his ability. A society such as ours has no choice but to seek the development of human potentialities at all levels. It takes more than an educated



elite to run a complex, technological society. Even modern, industrialized society is learning that hard lesson.

It is obvious, I think, that some of the people who are clamouring most noisily for quality in education are those who were never reconciled to the widespread extension of educational opportunity. To such individuals there is something innately indecent about large numbers of people.

At the other extreme are the fanatics who believe that the chief goal for higher education should be to get as many youngsters as possible -- regardless of ability -- into college classrooms.

Neither extreme, I suspect, expresses the true issues that confront us today. As has been said "we must seek excellence in a context of concern for all". A democracy, no less, and perhaps more than any form of society, must foster excellence if it is to survive and flourish.

This so-called dilemma, is, I think, examined exceedingly well in a book which came across my desk the other day. It's called "Transition: Policies for Social Action", a series of provocative essays on contemporary social issues, edited by Dr. John Fotheringham of Toronto. I would recommend it most highly to anyone interested in current educational and social issues.

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One of the essays, entitled "After High School, What?" starts off with the premise that too many of our students, and their parents, know only of the university-type programs at the post-secondary level and the result is that the majority of our young people attempt university-preparatory programs in the secondary schools.

This, combined with the financial difficulties involved in obtaining a university education, produces a double dilemma: Young men and women are wheedled into going to college who would be better served by some other type of training while others, who could benefit immensely from a college education, are denied the opportunity.

An associated problem, I suggest, is the tendency to plot the expansion of existing institutions and establish copies of them at minimum cost and with little alteration of their character and function. What is needed, and there are indications that this is happening, is a more imaginative attempt to determine not only the number of students to be served but the kinds of education that will meet their needs most effectively, and to devise a pattern of institutions designed to provide a wide range of educational opportunities economically and of high quality.

Educating everyone up to the limit of his ability does not mean sending everyone to college. And perhaps part of any final answer to the college problem can be found in a



revision of an altogether false emphasis we are coming to place on college education. Properly understood, the college or university is the instrument of one kind of further education of those whose capacities fit them for that kind of education. It should not be regarded as the sole means of establishing one's human worth. It should not be seen as the unique key to happiness, self-respect and inner confidence. Human dignity and worth should be assessed only in terms of those qualities of mind and spirit that are within the reach of every human being.

This doesn't mean we shouldn't value achievement; we should value it a great deal. It is simply to say that achievement should not be confused with human worth. Our recognition of the dignity and worth of the individual is based -- I hope -- on moral imperatives and should be of universal application. Being a college graduate involves qualities of mind that can never be universally possessed.

If we are to do justice to individual differences, if we are to provide suitable education for all, then we must cultivate a diversity in our higher educational system to correspond to the diversity of the clientele. Within one system, there is no other way to handle the enormous range of human capacities, levels of preparedness and motivations which come to the doors of our colleges and universities.



The highly selective, liberal arts college should not be afraid to remain small. The large urban institution should not be ashamed that it is large. The technical institute should not be apologetic about being a technical institute. This is the only way of achieving quality within a framework of quantity.

I know your main concern is with higher education, and more specifically, university education. But in your remarks, I would ask you not to ignore or overlook these two points:

The first is that the search for equality of educational opportunity -- universal accessibility, if you like -- starts long before you reach the university gates and involves problems outside the financial and educational spheres.

The second is that equality of educational opportunity means, not that everyone can or should go to university but that there be an equal opportunity to learn and grow in accord with their ability and capacity.

It is a pleasure and a privilege to be with you today; I trust that despite your busy schedule you will have time to see the scenery and sample the hospitality which are the hallmarks of this part of Canada.

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CANADA

*from the Office of the Minister of ~~Health~~ National Health and Welfare*

OR RELEASE AT

10:30 A.M., E.S.T.,  
Thursday, September 15, 1966

CHECK AGAINST DELIVERY

Notes for a Convocation Address by the  
HONOURABLE ALLAN J. MacEACHEN  
MINISTER OF NATIONAL HEALTH AND WELFARE FOR CANADA  
AT LOYOLA COLLEGE, BALTIMORE, MARYLAND  
September 15, 1966  
(ON THE RECEIPT OF AN HONORARY DEGREE)

THE HONOURABLE ALLAN J. MacEACHEN, MINISTER



My first pleasure is to acknowledge the great honor that you have given me. It has been said of Canadians that we suffer from three psychological obsessions in our relationships with the U.S.: We worry and fret lest our powerful neighbor will overwhelm us, or overlook us or take us for granted. You have not overlooked me or taken me for granted but you have overwhelmed me and for this I offer no complaint or apology. Indeed, I am honored beyond measure that you should consider me worthy of this high and undesired accolade.

I am proud to join the ranks of the graduandi of Loyola. It is an honor that many covet and some achieve through obvious merit and dedicated study; I have come by my Loyola more easily but they are nonetheless valued and appreciated. I am grateful that you should consider me worthy and I thank most sincerely those who have summoned me here.

I come as a stranger to most of you, perhaps, even, a curiosity, from that other half of this continent which -- although it shares your culture, much of your heritage and aspirations -- is determined to pursue its own national destiny.

Today, I hope some in the Baltimore area at least will know that a Canadian does have some resemblance to an ordinary mortal. Canadians have been referred to at various times as being the "most persistently unapologetically introspective people



on earth" -- to quote a prominent U.S. academic -- as hard-working, courageous, schizophrenic, great hockey players and, heaven help us, the greatest encomium of all, "just like Americans."

There is probably a bit of truth in all of these but Canadians aren't that easy to pigeonhole. We are a complex country, even more so than the U.S., despite our smaller population and some of our problems are ones that other countries -- including your own -- have gone to war about. There are benefits in having a big, powerful, rich and friendly neighbor on our side, to help with defence, to finance resource development, but it can also present problems; it is pretty hard for any national ego to swallow the fact that it must depend on someone else for military protection or to know that much of its important industries are owned and controlled by foreigners.

The highly-developed and almost obsessive sense of national pride developed in this country should make Americans that much more aware of Canada's sensitivities and make them more tolerant of and more sympathetic to Canadian efforts to achieve and maintain an acceptable degree of independence in political, economic and cultural fields.

Unfortunately, this tolerance and understanding is not always evident and the danger is that years of frustration





and erosion of the Canadian identity may lead to actions detrimental to both countries. To avoid this, and cultivate a climate of interdependence compatible with the aims and interests of both countries will require all our patience and goodwill and expertise. Canadians are said to be pessimistic by nature but I am confident we can work out our difficulties without erecting any spite fences.

It is trite but true to say that there is no relationship in the world quite like that between Canada and the U.S. As after dinner speakers are so fond of saying, we face each other across history's longest undefended border; we share most of what is probably the world's richest continent; indeed, it is the only continent divided by consent rather than force; our lands were first settled by people from the British Isles and Western Europe and we have developed political, economic and social institutions which, although far from identical, are compatible in all important respects; we have never fought against each other in this century but we have fought side by side, and for the same reasons, in three wars in the past 50 years; and perhaps most important of all, we share the same fundamental aspirations for the world -- a peaceful, prosperous future with justice and freedom of choice, free from force and the threat of its use.



But pitted against these common denominators is the ever-present and all-pervasive disparity in power and population. This is a fact which effects every aspect of our relationship; which has, is and will continue to place some pretty heavy strains on the bonds that have served to unite us.

Canadians are determined to remain independent; most of us, I think, are convinced that we have a destiny to fulfil; it may be a destiny we find difficult to define but we conceive it to be distinctively Canadian.

This may seem a self-evident, perhaps, even, a gratuitous statement. No U.S. Government, at least in modern times, has made any calculated, conscious, overt effort to interfere with our independence or to thwart the development of a Canadian identity.

Yet to many Canadians, there is a nagging awareness that this danger does exist; in fact, some will claim that it is already a fact, that our independence has already been eroded, our distinctive identity frustrated, by U.S. influences.

The realities of modern weaponry and international politics have already forced us to rely largely on the U.S. deterrent strength for the defence of



our half-continent. In the economic field, over 90% of Canadian automobile production, 50% of all manufacturing, roughly two-thirds of our oil industry are owned and controlled by the U.S. On the cultural side, many of the books and magazines we read, a large proportion of our movies and radio and television are American in content or character.

On top of all this, are the psychological problems -- some valid, some tenuous -- which are bound to arise when two entities of widely differing means occupy neighboring premises. Those of you who have taken Py 115 would perhaps label these problems a case of mass inferiority complex, on Canada's part at least. We continually worry that you will overwhelm us, economically if not politically; we're hurt if you take us for granted and we sulk if you ignore us. Added to this, I suppose, are our own self-doubts, our concern about whether our dreams of distinctive independent nationhood can, in fact, be realized.

Even one most proficient in the expertise of social psychology and economics would hesitate to give a final diagnosis and prescribe remedies for these problems within the limitations of a normal convocation address.

I would tell you only that our countries are interdependent, perhaps more so than any two other nations, and,





if for no other reasons, we have a very selfish interest in assuring that we respect each other's national integrity and economic independence. If we can't get along and work out our problems to the mutual satisfaction of both our countries, there is little hope for the rest of the world.

I think most Canadians are sincerely searching for solutions that are compatible with national goals and equitable to U.S. interests. With its extra-continental involvements, and more particularly its commitments to the defence of the free world, and its responsibilities as a great power, it is perhaps understandable that the U.S. should forget, or overlook problems closer to home.

And certainly, in the U.S. perspective at least, the fact that an American home-office of a Canadian subsidiary occasionally forgets that Canada is a sovereign foreign country, would seem to be pretty small potatoes, indeed, when set against the broad sweep of events in Vietnam or West Berlin.



On the world scene, the perspective is perhaps valid but this does little to ease the frustrations which Canadians experience when they feel that their economy, their culture, their political independence, is being drawn more and more within the ambit and influence of a foreign power. And it is no consolation, either, to know that this absorption is by default rather than by deliberate design.

It lies within the competence of both our countries to remove the major irritants that exacerbate Canadian - U.S. relations. As Canadians we are perhaps too touchy and are inclined to see some deliberate plot or ulterior motive where none exists and are too ready to look to the U.S. for remedies that are within our own reach.

Americans, on the other hand, are inclined to be too blase about Canada, too ready to take us for granted and to assume that we are really like Americans and should be counted on to react to nearly everything in the same fashion.

Surely there is some middle ground between these two extremes which can form the basis for intelligent, effective remedies.



The fact that you have asked me here today, for reasons which I am sure are as much Canadian as they are Catholic, is perhaps an example of what is needed. Despite their many similarities, Canadians and Americans are too often strangers and are inclined to look at each other in large, distorted generalities. In your case, I think this is because you don't pay enough attention to Canada and Canadians; in our case, perhaps we pay too much attention to the U.S., and form exaggerated and stereotyped impressions.

I am, as I said, a stranger to most of you but, though I may be a stranger in a personal sense, I am not, I assure you, unfamiliar with the traditions of this institution and its record of excellence in the field of education. Indeed, excellence and high scholastic achievement have for centuries been the hallmarks of Jesuit enterprises in all fields and in all corners of the globe.

In my own Province of Nova Scotia, our sons and daughters have been long-privileged to attend a Jesuit university and many of our country's leading figures -- in politics, in the professions, in journalism, in the arts and sciences -- are alumni of this institution. Indeed, my last public function, before coming here in Baltimore, was to take part in a political seminar last weekend at this university -- St. Mary's in Halifax.

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So, I think I know what brings you to Loyola; not just the high calibre of the education it offers, but the amenity and amiability of a compact, cosmopolitan faculty and student body and the prospect of a purposeful and challenging curriculum.

I am told, too, that one of the surest sesames to success in Maryland is a degree from Loyola. Your graduates have offered their training and experience at all levels of public life and I am sure that this week's primary left a fair share of Loyola graduates still in the running. I am sure that in this class, as well, there are young men and women who will follow in the footsteps of Senator O'Connor and bring new lustre to Loyola's name.

I am aware that today I am among the elite of the 1966 graduates of Loyola College. As class leaders and prize winners you naturally deserve the congratulations and laurel wreaths you are getting and will get. But I know that I do not detract from the lustre of your day, nor the pride of your accomplishment when I say you are not alone among the deserving. Your achievement is not solely a personal one; it is deeply rooted in this city and the community which it serves; in the strivings and sacrifices of your own families; in those who worked to build this school and who have labored so selflessly to create and maintain standards that are Christian and ethical as well as academic and educational.



Some will tell you, you are self-made men and women; don't believe them; many and varied currents have brought you to this long-sought goal.

As graduates of a liberal arts college, you enter the main stream of life with special qualities and special opportunities. And, as graduates of a ethically oriented liberal arts college you set out with special responsibilities, as well. But I would sound a note of caution; don't assume that because you have had a good grounding in philosophy you can solve all life's problems and complexities. What you have learned, and the context in which you have learned it, will no doubt help you towards fulfilment and satisfaction in your personal lives. But don't take it for granted that this automatically equips you with some magical touchstone which makes you an Ann Landers for all humanity.

To have the right ethical philosophy doesn't necessarily mean you have the proper instruments, the right techniques, to apply this philosophy successfully, to every day life. As any practical politician will tell you, to have a philosophy doesn't automatically mean that you have the programs and the policies -- the mystique, if you like -- to translate this philosophy into effective action.

To do this you need expertise -- expertise in the social, political and economic fields, expertise in the ways



and workings of mankind. And that, I think, is something that has all too often been missing in Catholic education. We are inclined to concentrate on where we are going in life -- and to ignore the basic bread-and-butter issues which confront and bedevil us as we live out our lives towards this immutable and all-encompassing objective.

This weakness could probably go undetected in earlier times, when men, individuals, were more the masters of their own fate and the outside influences -- of society, of economics, of political institutions and cultural phenomenon -- were unsophisticated and relatively ineffectual. But, in an age of overwhelming political, social and cultural problems, there is a great need for Catholic educators with an expertise in the complexity of modern-day society and a great need for men and women who not only know and accept the ultimate role of mankind but who can relate this in a meaningful way to the unprecedented problems and the great grey areas of mid-20th century life.

The Commonwealth Prime Minister's conference just ending in London is a case in point; everyone accepts that the real issue at this conference has been race relations; yet no-one seems to have the proper attitude towards solving this problem. As is so often the case these days there is unanimity in identifying the problem but a lack of agree-





ment, a scarcity of ideas, on the techniques which will produce an effective and ethical solution.

This, I suggest, points up the eternal validity of the small liberal arts college and the role it can and should play in producing graduates equipped to deal with life's myriad problems in a human -- and humane -- way. A famous educator, a native of this very city, once said: "I can never rid myself of the belief that the essential value of the university does not depend upon the discoveries it makes, or the knowledge it accumulates and imparts, but in the characters which it develops."

The highly-selective, small liberal arts college should not be ashamed to remain small. Size isn't greatness; size isn't quality. Now, perhaps more than ever, there is a need to preserve the small citadels of liberal arts which are the colleges such as Loyola.

Why preserve them? What do we look for in a liberally-educated man or woman? In one word, I would say we look for reason. In a world that is aiming for the moon, in technology, but which has yet to hit the ~~important~~ <sup>important</sup> ~~in man's~~ <sup>in man's</sup> relationship to man, we need minds that are switched on to the great social, economic and political issues of the day.



We need trained manpower, of course, if we are to meet the commercial demands of the technological age and the dictates of cold war politics. But training as such -- skill in a trade or proficiency in a profession -- is an incomplete education. It doesn't cultivate any great desire for knowledge, to understand and appreciate the great truths of the world, to be concerned about mankind, individually and collectively.

To me, a liberally-educated man is one who is willing to remain uncommitted because he realizes that the blacks and whites of an issue are not always what they appear to be at first blush. He is willing to consider ideas from every angle, in order to disclose unexpected and unforeseen aspects of human thinking. The end of the human intellect is to fasten upon truth; but there must always be those who realize that most men's intellects extend commitment a little too quickly to ideas never seen quite clearly enough.

This is all the more essential in an age when the push-button and the instant mix all too readily encourage push-button philosophies and instant ideals.

And even though one must love the truth -- and defend it -- we should also realize that the process of seeking it is more like a game than a war or a love affair. By training and intellectual osmosis, the liberally educated man is more apt to adopt this detachment, this cool willingness to explore



things in the area of the mind where one can hope to understand something without feeling any compulsion to suppress or destroy it. It is these qualities, this approach, which offer the best hope that men will learn to understand and tolerate each other -- perhaps, even, respect each other, despite physical, intellectual, political or social differences.

And it is the small liberal arts college which stands in the best position to properly transmit these qualities to those who come to them seeking knowledge and education.

These, I admit, are personal opinions and perhaps they are suspect coming from a person who has spent his entire adult life in university -- as a student and professor -- and in politics. I haven't had to meet a payroll and no doubt my views don't jibe with the hard-nosed businessman's approach to life.

Nevertheless, I am convinced the climate of the small liberal arts college is the best suited to give the world the interpreters and communicators it so badly needs. Loyola is in that tradition and I am pleased indeed to join the good company of its graduates.

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CANADA

2 Sept 66

from the Office of the Minister of National Health and Welfare

RELEASE AT

5 P.M., E.D.T.

Friday, October 7, 1966.

OFFICIAL NEWS RELEASE

Notes for an address by the  
HONOURABLE ALLAN J. MacEACHEN,  
MINISTER OF NATIONAL HEALTH AND WELFARE  
TO THE  
BRITISH COLUMBIA HOSPITAL ASSOCIATION,  
VANCOUVER, B.C.  
October 7, 1966.

THE HONOURABLE ALLAN J. MacEACHEN, MINISTER



One of the few fringe benefits of being a federal cabinet minister these days is the occasional opportunity one has of journeying from Ottawa on official business. And I can tell you that, among my colleagues, few of these opportunities are more cherished than the chance to come to British Columbia.

In this respect I have been more than fortunate; this is my fourth visit to British Columbia this year; I have been here in winter -- or what passes as winter in British Columbia -- in spring, in summer and now in autumn, and I can tell you that I have been increasingly impressed on each successive visit, by the variety of your view and the vitality of your people.

British Columbia is surely a province on the move; and, if I ever had any doubts on this score, they would certainly have been dissipated by the reading of a recent cover story in a certain American weekly news magazine. No politician that I know of, Canadian or otherwise, has ever had his picture on the cover of this magazine, pointing "this way to the bank".

After reading this article I have no doubt but that -- whatever problems you may have been discussing at this annual meeting -- none of them were even remotely concerned with such mundane things as money and finances.



Naturally, I am pleased to accept your association's kind invitation to join you today and to say a few words at this final banquet. As I said, it is always a pleasure to come to British Columbia and this is doubly true when it gives me an opportunity to speak to and meet with people involved and interested in the health services field.

My only regret is that I have not been able to take in more of your sessions, but I'm sure you understand why this has not been possible. And, although this is my first formal confrontation with the B.C. Hospitals' Association, I can tell you that I am aware of the work you have done, and are continuing to do, to improve services and to meet the needs of your member hospitals through the varied activities of your regional councils, educational institutes, and other facilities.

It is almost a decade now since Canada's national hospital insurance program went into operation. I am sure you are all aware of the role which the Government of Canada has played, and continues to play, in this program, even though some members of the public in this province may have been encouraged to think otherwise.

Perhaps, because of current developments in other areas of health services, I might be permitted a few observations on hospital insurance. Hospital insurance, in





the beginning, was not without its detractors -- people who warned that it would downgrade the quality of service, that it would prove an administrative nightmare, that it would impose difficult and dangerous demands on the economy.

There have been problems with the hospital insurance program -- as there have been, and will be, with any program of this magnitude. But I think it is fair to say that most of these problems have been of a relatively minor nature and have been worked out to the general satisfaction of all concerned.

Certainly, the fears of its more vociferous opponents have for the next part been proven groundless. Hospital insurance is now an accepted part of Canadian life and I doubt if anyone with any degree of objectivity or responsibility -- in politics or out -- would want to see it dismantled and the clock turned back to the old catch-as-catch-can days. This is true, I think, whether one looks at the program from the point of view of the patient or hospital financing and administration.

Drawing upon your own experiences and the experiences of other provinces, I think it can be said that hospital insurance in Canada has developed to a point where we are the envy of the world. Health workers from all parts of the globe



continue to visit our country to examine our hospital services and our insurance program.

Standards of patient care within Canadian hospitals have achieved a level where almost 85 per cent of all patient days are spent in accredited institutions. This, I think, is an impressive record.

At the same time, education for the health professions is expanding; in this province, for example, the Health Sciences Centre at the University of British Columbia is being widely acclaimed as one of the most outstanding, ambitious and comprehensive projects in this area.

The inter-relationships between universities and hospitals in training and developing members of the health team has been expanding rapidly in the last decade. This close relationship is opening broad new horizons and is one which I believe should be expanded and encouraged.

In looking at hospital insurance, while we may often concentrate our attention on the operation of hospitals -- and as trustees and administrators you are always examining your operational efficiency, your operating standards, and budgets, -- we must not forget that the primary purpose of the hospital insurance program is focussed on the individual patient and family.



Hospital insurance permits the individual to receive and obtain what we hope is the highest standard of hospital care possible within the limitations of our society. The provision of individualized hospital care is an aspect of the hospital insurance program which must be emphasized and programs must always be developed with this in mind.

In the beginning, there was a fairly widespread belief that universal, government-sponsored hospital insurance would somehow destroy individual initiative and personalized attention, that it was a major march down the road of socialism and could only bring regimentation and proliferating and impersonal bureaucracy.

If anything, both the calibre and extent of hospital care has improved greatly since the introduction of hospital insurance. Not only are more people getting hospital treatment when they need it, they are getting treatment of an increasingly high quality and more adequately geared to individual problems and personal needs.

Admittedly, a few subscribers may get overbilled or underpaid -- by some contrary computer, no doubt -- but isolated inconveniences are minor and minute when set against the obvious and undeniable advantages of hospital insurance -- advantages which accrue to the hospitals no less than to the public generally.





No person's life can be -- nor, indeed, should be -- worry free. It is fashionable, in this age of affluence, to mourn the days of the rugged individualist and to denounce the many things that governments seem to be doing for people. But surely we should keep our mourning and our denouncing in perspective. It is not, I suggest, demoralizing or degrading for a government to want to ease or remove the financial worry -- and it can be an all-consuming and catastrophic worry -- which invariably accompanies ill-health. To be sick, to require medical and hospital treatment is worry enough; to add to this the worry of how in the world it's going to be paid for, is inhuman, and unnecessary and uncivilized.

A quick assessment of the hospital insurance program gives a vivid picture of its impact on and involvement in the Canadian scene. Since the program came into operation on July 1, 1958, payments by the Government of Canada, to all provinces, has amounted to over two billion dollars (\$2,000,000,000).

Of this, over two hundred and twenty million (\$220,000,000) has been paid to the Province of British Columbia under the Hospital Insurance and Diagnostic Services agreement. It should be recalled that in 1958 only five provinces, including British Columbia, participated in the program; in the 1965 fiscal year the Government of Canada



paid the equivalent of over \$400 millions, almost half a billion, to the provinces.

The per capita cost for the five-year period from 1958 to 1963 rose nationally from \$21.23 to \$39.44 and it is now estimated at more than \$50.00 per capita.

Insured patient days per thousand population in 1961 were 1,759 and in 1964 they had risen to 1,855. Beds and cribs set up per thousand population in 1959 were 6.5 per thousand and in 1964 had risen to 6.9 per thousand. These figures indicate that the program is a dynamic one and one that is growing to meet the expanding needs of the Canadian population.

The hospital insurance program has never been thought of as being a fiscal program but one dedicated to the health of the Canadian population. In this area, I think it has met its obligations exceedingly well.

Even after eight years, the program is still being improved and extended.

The recent broadening of your provincial program to include additional types of hospitals is a commendable example. I am sure this extension will assist greatly in the development of an integrated and balanced program of hospital care in your province.



You would probably be disappointed if I did not say something concerning medicare. Many have asked questions about how the introduction of medicare programs will affect hospitals. It can be argued and, indeed, has been argued, that medicare on a universal basis would create an increased need for hospital services; that may be true but, by the same token, it can be argued that medicare -- in the long run -- can ease the growing pressures on hospital beds and services; it is sometimes forgotten that medicare can have important preventative aspects.

Medical diagnosis can be made at an earlier stage, and, by being treated earlier, the length of hospital stay can be reduced; indeed, early diagnosis and treatment may even eliminate the need for hospital admission. It is hoped that universal medical care will have this effect.

The Hospital insurance program -- which now covers more than 99 per cent of our population and which has proven to be one of our most successful social programs -- has paved the way for the introduction of the Universal Medical Care program.

Recently, the Government of Canada brought forward a third measure which, with medicare and hospital insurance, will help place health services of a high quality within the reach of all Canadians. This is the establishment of the

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Health Resources Fund, which will make available five hundred million dollars (\$500,000,000) for a fifteen-year period to help provide training facilities for professionals -- doctors, dentists, nurses and so on -- in the health field. While this fund will be channelled through the provinces it is expected that a fair share of the money will be used to help teaching hospitals in the work they are doing, not only as practical training grounds for physicians and specialists, but also in nursing education and other paramedical areas. Allocation of some of these monies will be made available to the provinces on a per capita basis and the present allocation to British Columbia, on this basis, will be approximately twenty-eight million dollars (\$28,000,000). This money will be matched by an equivalent amount within the province, making a total of over fifty-five million dollars (\$55,000,000).

In addition twenty-five million dollars (\$25,000,000) has been allocated to the Atlantic provinces to be used by projects in this area. Of the five hundred million dollars, an amount of one hundred and seventy-five million dollars (\$175,000,000) has also been earmarked for later projects on a national basis.

These areas of newer development in government programs create new challenges to those interested in the health of Canadians. This will be an exciting period, when health



services are available in a broad range of fields, and their integration will permit higher standards of care and health.

It is a cliché to say that Canada is a growing country; population is increasing steadily and, in the next twenty years, it is expected that our population will grow by at least another eleven million (11,000,000); this is the equivalent of our total pre-war population. And, of course, the growth in the city of Vancouver and in the province of British Columbia generally, will be responsible for a large part of this increase.

This means we will need more resources, more doctors, more laboratory technicians, social workers, and all types of health workers; and above all we will need a better distribution of our health services.

The people of Canada expect that the benefits of the newer advances will be made available to them; they expect, and rightly so, a high standard of patient care in our hospitals.

In meeting these needs, there are, and will be, problems for boards of trustees, administrators and doctors, nurses and all staff interested in patient care. And there will be problems for governments, federal and provincial.

Only through the cooperative efforts of members on the health team -- the professions, the hospitals, the



community and governments -- can these problems be solved without compromising the interests of the public and the professions who serve them.

This same cooperative principle, of course, also applies within hospitals and other related health services. The twin goals of regional planning and inter-hospital cooperation must become more than a concept if we are to be able to offer a standard of patient care and a variety of service in keeping with the abilities of our highly trained personnel and technical resources.

Changes and new approaches in hospital construction, administration and operation must be considered if the improved skills and medical advances of this generation are to be placed within reach of all segments of the Canadian public.

It would be inappropriate and, indeed, politically indiscreet, for a federal minister to lecture you on what these changes and new approaches should be. I know, in fact, that you are already in step with many of them and are working on practical and imaginative new approaches and techniques.

There is, for example, the question of how to make maximum use of this country's nursing personnel, including those who have withdrawn from the labour force but who are often available for part-time or specialized duties.





Another example is the encouraging work being done by many general hospitals in such areas as mental health clinics and other out-patients activities and new approaches designed to reduce the length of stay in hospitals -- and, at the same time, expediting the patient's recovery.

These, of course, are areas in which the role of the hospital must be coordinated and integrated with other community services and institutions.

Duplication leads not only to higher operational costs but to a poorer utilisation of professional resources. Just as boards of hospitals require the highest level of internal operational efficiency, so, too, must we look at the health needs of our population to see that they are met by proper location of institutions and services to avoid duplication and to guarantee high standards.

Cooperation of boards of trustees in this area is of vital importance because there are very few activities that are as important as the health care of our nation. We must learn to apply the newly developed techniques of systems analysis, market distribution, and operations research in analyzing our health services. We must understand fully the advantages to be gained by regional planning and cooperation.



Our institutions should be complementary rather than competitive. Only in this way, can we give reality to the objective which I'm sure we all share -- the good health of all Canadians.

I thank you for your courtesy and attention; it was a pleasure to accept your invitation, to come to your annual meeting and to again experience the hospitality for which this part of Canada is famous.

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ORIGINAL

*from the Office of the Minister of National Health and Welfare*

RELEASE AT: 12.30 P.M., E.S.T.  
Thursday, January 19, 1967.

CHECK AGAINST DELIVERY

Notes for an address by the  
HONOURABLE ALLAN J. MacEACHEN  
MINISTER OF NATIONAL HEALTH AND WELFARE  
to the  
WIVES OF MEMBERS OF THE  
ROYAL COLLEGE OF PHYSICIANS AND SURGEONS  
at the  
COUNTRY CLUB, AYLMER ROAD, P.Q.  
January 19, 1967

THE HONOURABLE ALLAN J. MacEACHEN, MINISTER





Most of you, I'm sure, have had lectures enough on the ramifications of medicare -- at the breakfast table, no doubt -- and it would be most indiscreet for me to try to persuade you to reorganize any preconceived views you may have. Being married to doctors is a demanding enough task without complicating matters further by turning you into missionaries for medicare.

I would, however, venture one comment. I suggest, not naively, I hope, that when programs of comprehensive prepaid medical insurance are in operation around the country, you can look forward to seeing your husbands more often.

One of the long range benefits of universal access to the top-calibre medical services and facilities we have in Canada will, I think, be a healthier population. People will go to their doctors more regularly, and earlier and the opportunities of early diagnosis and treatment will be correspondingly increased.

Prepaid, nationwide universal medical insurance will, I suggest, also give doctors a wider choice of location when they come to decide where they will set up practice.

There are many communities in Canada which have lost doctors because they couldn't earn an adequate income, or can't attract them for the same reason. These communities need doctors, and I'm sure many practitioners would like to locate in such areas. But not enough of the prospective patients could afford to pay for their services and the doctors either move to larger urban centres or stay in metropolitan areas throughout their careers.

A universal, prepaid medical insurance scheme will, I feel, enable doctors to move into smaller, low income communities and still be assured of a steady, reasonable income. Also, it is possible in a public program to provide special incentives which will encourage doctors to practice in areas

...



which may not have the attractions and security of large, thickly populated urban centers. And just as important, the citizens themselves will be able to seek medical attention without having to rely on either the generosity of the physician involved or the aid of local welfare agencies.

When medicare comes perhaps some of you can persuade your husbands -- if you haven't already -- to move to a relatively quieter, slower-paced rural practice, with the assurance that his income will be such as to keep you in the style -- and fashion -- to which you have become accustomed. There are friendly and beautiful communities in my own constituency -- Inverness-Richmond -- where I know you would be made more than welcome.

I thought I might speak to you a few minutes about politics -- not Liberal or Conservative or NDP politics but politics in the generic sense -- what all these men, and a handful (or perhaps I should say, armful) of ladies are doing, or trying to do, in that national operating theatre known as Parliament.

There are many parallels between politics and the practice of medicine; maybe that's why so few doctors run for Parliament -- they know beforehand what to expect and exchanging a practice for a seat in Parliament is no more than the proverbial transition from the frying pan into the fire.

Like you, the wives and families of politicians have to share their husbands -- and fathers -- with the public at large. Neither the doctor nor the member of Parliament has a nine-to-five job; it is a round-the-clock operation.

The income problems of a widowed pensioner in Marble Mountain or the need for a new fishing wharf in L'Archeveque can, in their own way, be just as crucial and deserving of attention as a ruptured appendix or an outbreak of Asian flu. For a doctor the stakes are often life and death. The



alternatives are rarely as stark for politicians but often what we do, or don't do, can mean the difference between social or economic life or death.

There is one contrast, however. While there are many unknowns in medicine, challenging horizons to be charted and conquered, each day brings its quota of major successes and modern-day miracles. An x-ray, an injection of some wonder drug, an hour's work by deft and knowing hands and a crisis is solved, a pain is eased, an illness cured. What was impossible yesterday becomes tomorrow's commonplace.

Unfortunately, and perhaps unavoidably, the profession of politics -- if profession it be -- and the instruments and techniques of government do not lend themselves to the swift and sure solution of the great social and economic problems of the day.

There are no guinea pigs on which the theories of government can be tried beforehand, to test their effectiveness and toxicity; there are no injections that will tranquilize a faction determined to frustrate the obvious will of the majority, no x-ray that will reveal a fatal flaw in a seemingly healthy piece of legislation.

By its very nature, politics can never become an exact science, nor can Parliament ever become a model of efficiency and decorum.

But I do think we can do a great deal to improve and update Parliament's legislative machinery and to make Parliament a more effective place for dealing with the problems and issues of the mid-twentieth century.

I suspect that if the medical profession had been as slow and as reluctant as Parliament to modernize its practices and procedures, the doctors of today would still be prescribing blood-letting and ordering their patients to wear amulets to ward off contagious diseases.





In politics, the simple fact is that institutions and practices developed under one set of conditions, and designed to fulfill certain specific functions, have been perpetuated under quite different conditions when old tasks have disappeared and new tasks have been added.

The reform of Parliament is a task we can't leave to a Royal Commission and it is a task which a government alone cannot perform effectively. We have to reform ourselves, by discussions and agreement on all sides of the House, and the first question we must ask is how far our old procedures fit the new functions which a modern Parliament has to fulfill.

A minority Parliament presents many difficulties and drawbacks, particularly for a government, but in the area of procedural reform at least, it offers some opportunities. In a minority atmosphere, there should be a minimum of suspicion that the government is trying to force through procedural changes to hamstring the Opposition or to improve its own position. A minority government can't do this because it is outnumbered by the Opposition.

This, I suggest, presents a good climate in which members from all sides of the House can get together and work out a cooperative approach to Parliamentary reform. And they can approach the problem knowing that the results will not work to the partisan advantage of any particular party but will restore Parliament as a respected and effective instrument of democracy. If this is done, all parties, and more important, the public, will be the beneficiaries.

There is one other thought I would leave with you.

We talk about updating the machinery of politics -- streamlining and modernizing parliamentary procedures, reforming our election paraphernalia and so on. This isn't the final answer, or the only one. These reforms are needed but shouldn't we also be concerned about updating the mentality of politics?



Just as a pleasant and personable bedside manner is often as important as medical expertise in a doctor's career, so are proper parliamentary manners and attitudes essential to the effective functioning of our parliamentary institutions.

No democracy can ever streamline its political machinery to the point where opportunities for obstruction, procedural sabotage and prolonged debate are eliminated. If it did, it would no longer be a democracy because to remove all rules capable of abuse would be to remove those which distinguish a democracy from a dictatorship.

In a parliamentary system it will always be possible for those with a misguided political mentality to abuse the rules and prevent the parliamentary machinery from functioning effectively and properly.

This is not to suggest that there shouldn't be debate and discussion and the strong advocacy of views strongly held.

A democratic legislature presupposes that formal decisions will be made only after the Opposition has been given a hearing and had an opportunity, not only to influence the policy proposals under discussion but also to present alternative proposals.

Of necessity, then, democratic legislative decision making generates conflict. But it should be conflict with a purpose, a conflict of policies and philosophies rather than a conflict of personalities.

It takes a certain political mentality, a certain attitude of mind, to pick out the issues involving matters of great public concern and high principle. Almost any incident in Parliament, any bit of legislation, any comment by a member, can, with an inventive mind and an agile tongue, be built up into a headline-grabbing furore. All you have to do is to insinuate, as was done recently, that because a



minister has just returned from an official visit to Russia, he is determined to adopt communistic tactics in the House of Commons.

No responsible government can ever hope to completely satisfy its opposition or to accede to all its demands. Nor can it ever hope to bring forward policies and programs which will be always and universally acceptable to the public.

But I do think that in recent years -- perhaps it's the result of conditioning by a series of minority parliaments -- there has been a tendency to look at problems in an overly partisan way and to take up parliamentary positions which are more appropriate for an election campaign than a serious-minded legislative assembly.

Often, when legislation is brought before Parliament these days, I am reminded of the story of the husband who had a particularly bad case of breakfast blues.

On a certain morning, this husband got up in a particularly bad mood and his wife asked him what he would like for breakfast.

"Two eggs", he growled.

"How would you like them done, dear?" she asked.

"One fried, one boiled!" he snapped.

His wife went about the task, rattling pots and pans as little as possible, and the husband buried himself in the morning paper.

In due course, the wife placed a fried egg on the table and was met with a growl and a scowl.

"What's wrong, dear?" she asked.

"Can't you do anything right?" the husband asked. "You fried the wrong egg."





Too often, I think, parliamentary criticism is no more than a complaint that someone has fried the wrong egg.

It is not enough, I suggest, to argue that in times past, Parliament was a place for the violent clash of personalities, that the dusty records of parliamentary debates are strewn with controversy and calumny far more hectic and heated than any of those of more recent vintage. This may be true, but we are living in different times; the tactics, the techniques, the thinking of yesterday are not in tune to what the public expects of today's politician -- as a parliamentary performer.

On the hustings the political buffs and partisans still require fire and fervor from their politicians -- perhaps more so than ever before because of the competition of television and other diversionary activities. But once in Parliament, the public expects a member to be reasonable and responsible.

The public, I suggest, demands a businesslike, no-nonsense approach from its parliaments and legislatures. We live in a fast-moving, kinetic age and all institutions -- whether it be a commercial business, a university or a parliament or legislature -- are expected to be proficient, productive and public-spirited. Gone is the leisurely pace of yesterday when problems could be allowed to age and ripen while politicians shadow-boxed and conjured up imaginary issues. The problems have multiplied and have become far more complex; governments are involved in many more issues and activities and Parliament can't afford the time for forensic frills and procedural preening. Matters crying out for governmental and legislative attention pile in on top of each other with amazing rapidity and, in an automated age, the public increasingly demands that their law-making bodies, their parliaments and legislatures, take on the swift, streamlined and sophisticated qualities of computer and push-button operations.



Yet in an era which is continually achieving the impossible, Parliament is one of the few mechanisms which cannot be automated or computerized. Parliament is essentially a human entity and as such will always be subject to human limitations. Procedural reform can help curb some of Parliament's more obvious abuses but like so much else in modern-day society, its success and strength depends primarily on reforms in the mentality of its members.

It may be that some changes in the rules could have averted some of the episodes which have bedevilled recent Parliaments.

But even had we had these safeguards, it would still be possible for partisan schemers to derail or subvert the legislative process.

Parliament can never protect itself from individual irresponsibility.

One determined and irresponsible mind can derail Parliament; it requires the care and conscientious cultivation of all members to make it function effectively.

I make these few observations only to indicate some of the limitations of Parliament and to show that the mentality of its members as well as its machinery has a great deal to do with its effectiveness as a decision-making body.



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OTTAWA

*From the Office of the Minister of National Health and Welfare*

RELEASE AT: 10 P.M., E.S.T.,  
Tuesday, January 24, 1967.

CHECK AGAINST DELIVERY

Notes for an address by the  
HONOURABLE ALLAN J. MacEACHEN, M.P.  
MINISTER OF NATIONAL HEALTH AND WELFARE

to the

WESTERN CATHOLIC CONFERENCE  
EDMONTON, ALBERTA, MONDAY, JANUARY 23 - 8 p.m.  
CALGARY, ALBERTA, TUESDAY, JANUARY 24 - 8 p.m.

THE HONOURABLE ALLAN J. MacEACHEN, MINISTER





It is a pleasure to come west again, to Alberta, and an honor beyond measure to participate in this conference.

As is the case in so many other Canadian activities, a fresh wind from the west -- though not always as caressing as your famous Chinook -- is giving new vitality and new vistas to religious activity.

While preparing myself -- perhaps fortifying myself is a better description -- for this encounter, I had occasion to talk to a considerable number of religious spokesmen in and around Ottawa; I can report, on the basis of these discussions, that this Conference is considered one of the finest and foremost examples of what should be occupying the time and the energies of religiously oriented people in the modern world.

If I can use a political -- but not partisan -- parallel, I would suggest that this conference is doing for catholicism what the western delegation did for liberalism at our party's recent national meeting. This is injecting vigorous new ideas and energetic, imaginative thought on issues of vital public interest and concern.

And without in any way detracting from the work of the many others who have been involved in organizing and planning this Conference, I would say that a great deal of the impetus can be traced to the influence of the "Reporter". I have been following the Reporter since it first appeared on the publishing scene and I have been greatly impressed by its initiative and its in-depth approach to the great social and spiritual issues of the day.

As I understand it, my task tonight is to deliver a lecture, to set the scene for a series of the seminars on the church in a changing world. It's a long time since I delivered a bonafide lecture -- 1953 to be exact. I cannot produce a testimonial to my former abilities as a university lecturer; I can only hope that my years in the eye of the political hurricane have not deprived me of my lecturing license. I may have to go back to the job some day.

There is nothing more valid, or more obvious than the theme of this conference -- the changing world.

Man is on the threshold of a new society. Not the Great Society, or the Just Society, or any of these political Vallhallas but the New Society, a society which is almost upon us, a society which you will be caught up in, no matter what politicians say, or Parliaments decide, or churches decree.



What will this new society bring? Perhaps it can be most vividly portrayed by an example from industry; within a few years, it will be possible for many manufacturers to go directly from mechanical drawings to finished products by way of the computer. Human participation, physical labor, would be all but eliminated. It takes little imagination to contemplate what this can mean in terms of employment, education, income, leisure time and all the many other ingredients which are an accepted part of every day life.

Our job is to see that this society brings the greatest possible good to the greatest number of people, to see that it is a boon rather than a bane; we can direct it, alter its course a bit, but we cannot stop it.

Historians will label the Sixties as an age of transition; in this decade, we are marking the end of one era and the beginning of another. Old values are being challenged on all sides, new ones are being embraced with widespread enthusiasm. This is happening within almost every facet of human activity; it is the age of ecumenism yet there are widespread divisions within individual churches; in Canada we have geographical splitlines as well as cultural ones, a widening rift between rural and urban peoples, conflicts within labor unions, philosophical chasms within political parties.

This, I suggest, is a natural concomitant of transition. New ideas, new techniques, new technology, sprout almost overnight; yet there are still many who unquestioningly adhere to the old values, the old ways even though the new -- whether it be the new morality, or the new technology or the new social order -- may be perfectly acceptable to you, don't forget there are many others to whom these new manifestations are repugnant or, at best, an unfathomable and threatening unknown.

In Canada, in the economic sphere, we are marking the end of the era of scarcity. We have already felt the full impact of the second technological revolution. The era of great innovations in the field of traditional social security is over. The new society will force the abandonment of long-accepted approaches to social security and the development of completely new techniques and the espousal of approaches which are perhaps now regarded as heretical.

The new society will be affluent, it will be in constant and rapid change; the problems these conditions will engender are not ones that can be met with social programs geared to readily identifiable, economically disadvantaged groups. These areas will still cause concern but the great problems of the new society will be the products, or by-products of affluence.





A society becomes affluent when the average man prefers to work less rather than to earn more, when he is protected against the main economic risks of life, when he has as easy access to education and he devotes a declining portion of his income to basic necessities.

Canada is now reaching that situation. In the past 25 years, the working period has declined by 30%, a real income per capita has doubled and a comprehensive system of social security is being established: medicare, I would say, will close the last major gap.

Affluence is the oldest dream of humanity. We used to believe it would solve all problems. It doesn't, of course. It solves some of the old problems, true, but it creates new ones. In the affluent society, the poor feel poorer; the traditional privileged classes (politicians, for example) are overworked and this leads to all kinds of personal and family difficulties. For the average man, affluence can too often mean frustration, psychological insecurity and boredom.

The fact is that in achieving affluence, we have succeeded in destroying, or replacing, man's natural environment. Our water and air are polluted; our cities have been built without being planned; serious and seemingly chronic pockets of poverty dot the economic landscape. The consumer -- if she isn't on strike -- has a greater freedom of choice but she is subjected to the frustrating necessity of establishing priorities when she hardly knows the quality of the products offered her.

The traditional sicknesses of the era of scarcity are disappearing but the ailments of civilization -- especially those of the soul -- are spreading. The affluent family is losing its traditional roots; it asks for new approaches -- moral as well as legal -- to the problems of birth control and divorce. Leisure demands urgent, and global attention.

These are but a few of the problems which the new society intensifies or creates.

For governments and nations, generally, this creates one encompassing and over-riding danger; it is that we will stay geared to the major collective effort which was required to achieve affluence, and forget or overlook the need to adjust to this affluence.

This individual and collective adjustment will require new attitudes, new institutions, new policies. We've met these challenges before but there was time to adjust; we had time to become familiar with problems, and policies to deal with them could be expected to remain valid over a considerable length of time.





This time, there will be no such cushion, few such static situations. As we are achieving still newer, a third major technological revolution is upon us.

The new era is already the atomic age; it is becoming the space age, and, before long, it will be the age of cybernation -- the product of the marriage of automation and electronic brains.

Since the steam engine, we have been producing bigger, better and more sophisticated machines, which more and more are extensions of the human body. Today, we have machines that can reproduce or duplicate the most complicated movements of the body; only they do it more rapidly and with fewer mistakes.

Even more amazing, we are now turning out intellectual machines capable of matching, and even exceeding, the mental processes of man. They can learn; they can detect and correct their own mistakes; they have "memories"; they can think as originally as a man of average skill.

The new society will involve -- primarily -- a revolution in methods and techniques of production. The physical and intellectual work done today by man will be performed more and more by machines. Your children, perhaps you, yourselves, will live in a "cybernated" world.

Even if progress stopped now, the full consequences of the new inventions already made would be far-reaching and all-embracing. But the fact is that scientific progress will be even further accelerated. There are approximately 1,500,000 researchers in the world today. They represent more than 90% of all those who have lived since the beginning of humanity. And perhaps the most frightening aspect is that most of these are concentrated in the fields of physical sciences -- inventing new things, new machines -- rather than in the social sciences -- trying to find new ways to ensure that these physical advances will make for human betterment and fulfillment.

For the first time then, humanity is entering into an area of permanent scientific revolution. Humanity itself is being propelled into orbit by its own scientific achievements and will remain in perpetual motion for the foreseeable future.

In adapting to this perpetual orbit, evolution will no longer suffice; we cannot let the past determine the present. Rather, from now on, we will have to look to the future to decide the present if we don't want to be perpetually in the position of producing solutions for problems that have already disappeared.



This permanent revolution, if left to itself, will inevitably produce chaos and anarchy. The keys are planning and adjustment -- present planning for future revolutions and adjustments to the changes that will accompany them.

In the age of the permanent scientific revolution and the electronic brain, education will cease to be a choice, a privilege for those who have the cash to swing it. Neither should it be restricted to the youth phase of the life cycle. Education will have to be free, to all, at all levels -- and permanent. We must have facilities and machinery which offer continuous opportunities for retraining to the many whose skills will be replaced by machines and automation. New manpower policies which break with the traditional patterns which sprung from the industrial revolution, will have to be devised. I doubt but that a generation is not far which will look back and marvel at the drudgery, the deadbeat dogmas which bedevilled man in the mid-1960's.

Adjustment to change should also be extended to our political institutions -- which have not been substantially modified since the 19th century.

We have made a bit of progress in the past few years in the area of Parliamentary reform but many of the trappings and traditions of the Victorian era still impede its performance and progress. One proposal worth considering is that we establish a permanent committee, which will keep Parliamentary procedure under continual review and put forward acceptable reforms.

The cybernatized age may call for a complete re-vamping and revision of our social security programs and approaches.

Social security is of direct concern to me because of my responsibilities as Minister of National Health and Welfare and perhaps I might make a few observations in this area.

This, Mr. Chairman, is perhaps the area which must change most, where the most drastic rethinking must take place, if we are to extend the benefits of the new society to all.

There already have been some fundamental changes in social security approaches.

The idea that work was necessary and good and that the indigent should be driven to it continued to dominate



thinking about welfare assistance until recent times. But eventually, the community did recognize that there were certain groups or classes who could never provide for themselves. As a result certain meagre benefits were provided to groups such as widows with dependant children and the blind. To protect the public purse, stringent means tests were imposed. Benefits were usually paid in kind rather than money, for an indigent could not be expected to manage his own affairs or to use cash wisely.

In the last generation or two, our economy has developed into a much more complex and diverse structure. Changes have also taken place within our society. As a result, new concepts and a different appreciation of the individual, his family, and their relationship to society have evolved.

You are aware of the economic and social changes which the industrial and technological revolutions have wrought -- the concentration of resources and manpower in large metropolitan areas, the moulding of the family into small, two-generation units, the individual's loss of much of his ability to influence the forces of the modern marketplace, the increasingly active role which governments must play to provide services which will protect and advance the interests of the individual family.

Even today, we see many families trapped by their environment; families who cannot see any way out. They may be dependent on public assistance, see no likelihood of steady employment because they have no skill or job opportunities and the problem is compounded by a crushing burden of debt and by inadequate housing. The whole situation creates emotional problems and strains family ties.

The new concepts of the role of government and the increase of community wealth have been brought together. The concept and the fact, when united, make possible new visions of affluence but at the same time call into question certain basic concepts of our work and wage system.

The individual no longer is considered as someone apart, independent and self-reliant. He is a member of a community and he is entitled to services provided by government from the collective wealth of the country. This immediately raises a question -- how many services should be supplied by the state and should they be supplied to everyone, or to those who pass a test?

We now have a combination of such programs in operation -- some available to all, such as hospital insurance and contributory pensions, and others limited to certain disadvantaged groups, the aged, the disabled, and so on.







These measures reflect the sense of responsibility by the community for its individual members. They provide basic income for certain groups and basic necessities such as hospital and medical care. In the light of such measures and their obvious benefits, thoughtful men have begun to ask whether they cannot be applied to other fields.

Economists such as Galbraith point out that with our affluence there is no longer an excuse for indigence or even for poverty. They ask whether enough resources in the form of social capital are being provided to the poor and to all classes. With the increasing affluence, the fact that there are employed persons who are poor suggests that our present job-salary structure is failing to distribute the wealth in a fair manner.

The intellectual products, the ideas, of a world in which poverty had always been man's normal lot, cannot be applied effectively to the problems of the affluent age. The short-comings of economic and social security approaches have not been original error but uncorrected obsolescence.

What are some of the new approaches?

Several social scientists and economists have suggested guaranteed incomes of various sorts. The proposals imply that the government should transfer sufficient wealth to every member of the community to meet his basic needs. Such a concept completely reverses the 19th century idea that income is a measure of a man's worth. The new concept would to a great degree divorce the long-standing link between work and income.

This, I might note, is a question which is not confined only to politicians and sociologists. Archbishop Jovan, in a statement to the Vatican Council in Sept. 1965, recognized that the "traditional link between productive work and family income may have to be modified and other means to income discovered...". He went on to point that "leisure time creatively used can fulfil some of the greatest spiritual and intellectual capacities of man."

Our ancestors would have argued that to take this step would demoralize the population and lead to a stagnant and dissolute nation. But, if we look at Canada today, we see a nation with a higher standard of living than ever before. Our work force is expanding and new techniques are being introduced daily which increase productivity. This work force is better educated and better able to enjoy wisely the benefits of its labour than did its over-worked and under-paid counter-



part of a century ago.

This is not to say that there are no problems. We can, however, suggest that our ancestor's view of human nature is more pessimistic than our experience has proved. After all, our political system is based on the belief that our citizens are reasonable persons and will so respond. To exploit men and treat them as animals, as was done in the 19th century, would naturally lead them to respond in kind.

The divorce of income and work concept was conceded to a degree in the recently enacted Canada Assistance Plan, which one expert in the social welfare has described as "perhaps the greatest departure of all in the provision of public social services since Canada became a nation". Basic to the Plan is the old concept, that the state should provide for persons who cannot cope with the economic system. At this point, however, an essential innovation has been made. Applicants for assistance are entitled to receive assistance as a right if they are in need. Further, the provinces will provide such persons with adequate assistance to ~~meet~~ <sup>meet</sup> their basic requirements.

Should the federal government go a step further and provide a guaranteed minimum income? If it did, it could establish the much desired national standard for basic needs. Further, it would free provincial funds which might then be used to develop services. What would be the effect of such a policy on the economy and on the recipients? What should be the objectives in introducing some such scheme?

It is perhaps true that automation thus far has not put as many people out of work as had been originally expected. But as Theobald points out in his book "The Guaranteed Income" the great impact of automation and cybernation on employment will not be for those already in the labour force; these, for the most part will be protected by union-management agreements and by such programs as on-the-job training and such. The shuddering implications of cybernation are for those who will be entering the labour force in the future, in the 1970's and 1980's and later. For them cybernation will almost certainly mean a narrowing of job opportunities, a considerably reduced chance of being hired in the first instance, limited incomes.

These are some of the directions, some of the developments, some of the questions, we should be examining in the social security field, some of the challenges and goals of our newly emerging society. We are now caught up in the fringes of this new era; some of you may see its full realization; certainly, your



children and your children's children will be in the centre of it.

The question you will be considering over the next few weeks is where you as members of the laity in a modern, changing world, fit into this. What should you be doing, what new approaches and initiatives are required on your part to ensure that this new society is also a great society, a just society, a humane society?

The guidelines in which we will find the solutions have already been set, by Vatican II, and by the dialogue which is now pulsating through the world's churches.

The Christian focus is being more and more centered on "the value of the human person". This is something which transcends religious ideologies, something towards which all men of goodwill can work.

In the past, I think, there was a tendency to focus on dogma, on God, if you like. A lot of us failed to realize that you can find God through man, that for the lay individual, the way to spiritual salvation is primarily through temporal things, what we do here on earth in our everyday activities and in our contacts with our fellow men.

By centering on the value of the human person, Vatican II has extracted the common denominator of all the world's religions. There are, and will continue to be, ideological differences, we may not agree on why we value the human person -- Catholics will say it is because we are all children of God, others will give other reasons -- but there is a consensus on this one over-riding point, the dignity and value of the human person.

Mankind must have a consensus of values if we are to survive. In our own country, in Canada, the need for a consensus is as imperative as elsewhere. If we end up with two divergent ways of life, two consensus, we will not long survive as a country.

It is not, for example, a question of whether this consensus should be French or English, any more than it should be Catholic or Protestant, black or white, Asian or American. A true consensus has nothing to do with racial pedigree or religious dogma or skin pigmentation. It is, in fact, based on that one and transcendental thing which we all have in common -- humanity.

A consensus comes from looking reality in the eye, and determining what is best and possible. Often, if not always, it involves compromise.







The best shouldn't be the enemy of the good. We shouldn't turn our backs on what is good, simply because we cannot have what is best.

Today's dialogue, whether it be with Communists, Conservatives, Materialists or Marxists, is possible because of compromise. It comes from setting your values against those of others and determining where you can agree and where you can work for the good of humanity and the community.

There are many things on which we can agree -- and they all have to do with man as a human social animal. It is good for men and women to pray together but there is more rapport and understanding when we do things together which recognize the value of the human person.

The cooperation between the churches is focussed on the social rather than the spiritual or ideological activities.

Twenty years ago, perhaps even a decade ago, when a Catholic expressed concern, he went out and built a "Catholic" complex, a "Catholic" centre, or some such. Today, you are more apt to find this concern expressed in terms of the community as a whole. If there is a community project underway, or a great social question exercising the public, chances are you will find the churches, lay members as well as clerical working together towards a common objective.

These changes, I suggest, are a direct result of the emerging new society. Technological advances, industrialization, urbanization, are throwing the peoples of the world closer and closer together. We are more and more faced with the dilemma of either fighting each other or loving and respecting each other.

A century ago, it was relatively easy to love one's neighbor -- in theory at least -- because usually he lived a mile or an ocean away. But modern society is throwing different peoples, races, religions and cultures face-to-face and back-to-back and the alternatives of daily life are either to love or to loathe.

And again we come back to the key, the only sesame which holds out hope for mankind's spiritual salvation and temporal survival -- a common belief, a consensus, in the value of the human person. This is the way to peace, to the elimination of poverty, to racial tolerance and understanding.

To leave the world, to withdraw to some semi-spiritual plateau, should no longer be the aspiration of those who would serve the Lord. As someone else has said



(Michael de la Bedoyere): "no solution to the world's problems can be deduced immediately from Christian dogma. The conscience of lay Christians must mediate between dogma and effective action, that is, actions directed intelligently toward precise conditions of time and place."

We are faced now with these precise conditions of time and place and almost before we will have time to deal with these we will be engulfed in the varied and far more vexing problems of the new society.

The Roman Catholic Archbishop of Edmonton in a statement at the Vatican Council on Sept. 22, 1965, referred to a world "cruelly divided by an abyss that separates the rich from the poor". He went on to say that our contemporaries "will be very encouraged to see Christians.....insistently urged to become more closely identified with the great mass movements of our time -- movements for peace, for freedom, and for the alleviation of poverty."

If a consensus on the worth of the human being means anything, it means that all Christians, all men of good will, must, whatever their religious ideologies, throw their lot in on the side of these great movements.

A civilization without peace, a people without freedom, an affluent society which permits underdevelopment of personal talents or physical resources, is neither Christian nor human.





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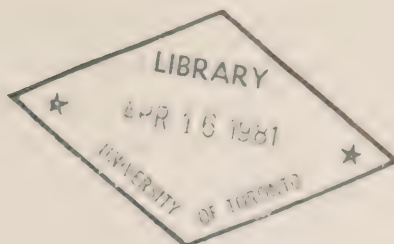
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The Honourable Monique Bégin



NOTES FOR AN ADDRESS

BY

THE HONOURABLE MONIQUE BÉGIN

TO THE

BANQUET OF THE NATIONAL PENSIONS CONFERENCE

APRIL 1, 1981







Ladies and gentlemen, I would like to begin this address by thanking each and every one of you for coming and participating in this historic Conference. In the past several years as Minister of National Health and Welfare, I have had the privilege of being the guest of many of the groups you represent. This has given me the chance to discuss pension issues with many of you, and to see your viewpoints on those problems and the possible solutions. I have invariably been impressed by the sincerity of all the partners and their commitment to building the best possible pension system in Canada. I have found that desire to be common to pensioner groups, labour organizations, women's groups, employers, pension managers, the insurance industry, social development groups, economists, and many others.

And if anything has become clear to me in meeting all these groups, it is that no one individual or organization has the single, definitive answer to our pension problems. That is why this Conference is so important, because it is the first time that representatives of so many parts of our pension system have gathered to discuss the problems and issues together. And speaking selfishly, if it only helps to sensitize everyone to the difficulties governments face in trying to reconcile so many different and sometimes contradictory views, then the government may consider this Conference to have been a resounding success. But of course, what we are really seeking is not sympathy, but solutions.

In looking for better solutions, I have not confined myself to talking only with Canadians. I have made it a point to look at the systems of other countries and I have taken advantage of my responsibilities in the field of international social security to travel abroad and see for myself how other countries have dealt with issues very similar to those facing us here in Canada. Last fall, I had a chance to visit with Ministers, officials, and private sector organizations in four European

nations - France, the United Kingdom, West Germany and Sweden. Their experience was of special interest to me, because in several cases they have already scaled that so-called "pension mountain" that we hear so much about. That phrase, is, in fact, a translation of a word coined by the West Germans, which I hesitate to try here - the "Rentenberg". Frankly, from the way some people approach this issue, you would think the word was "iceberg" and our pension system was the "Titanic".

There has been a great deal of discussion and concern about the problems we face in the future in supporting a growing pensioner population if current demographic predictions hold true. But in Europe they are already dealing with a pensioner population which is proportionately as large or larger than it will be in Canada well into the next century. From their experience, I believe we are given some valuable insights into our own capacity to provide a decent living standard for our pensioners, now and in the future.

Just over a year ago the Economic Council of Canada published a report called "One in Three". The title refers to the prediction that pensioners will account for one third of the adult population in Canada by the year 2030. That means that there will be only two workers for every pensioner fifty years from now. This is exactly the situation in West Germany today. West German officials told me that this has indeed caused some problems, which have been aggravated by an economic slowdown following the oil crisis and by the introduction of a very generous and popular early retirement provision. This did not, however, cause the economic collapse or social security bankruptcy that some of the more pessimistic prophets have predicted for Canada's future. Instead, West Germany was able to get its plan back on a sound financial footing with some relatively minor adjustments. The most notable measure was a temporary cap on indexation. However, to put this in perspective, I should point out that the public pension plan in West Germany is indexed to

wages. This generally results in larger increases than the price indexation we have for Canadian public retirement benefits. Thus, in spite of the temporary cap on indexation, West German pensions have still been fully protected against rises in the cost of living.

I might also mention that the private pension plan system in Germany also has a provision for cost-of-living increases.

Another fact that particularly impressed me was that, in Germany, only 2 percent of their pensioners require any income-tested public assistance on top of their pensions; compare that with the 53 percent of OAS recipients in Canada who also receive GIS.

One thing I saw very clearly was that there are striking differences in the approach to pensions from one country to the next. Principles which are considered fundamental in one place may be totally disregarded elsewhere. In France, for example, their private plans are not fully funded as they are here in Canada. Instead they operate on a pay-as-you-go basis with liabilities of the various plans shared by other plans across the country through a system called "répartition". This very unusual system evolved after repeated monetary crises had shaken public confidence in the value of pension funds.

Private plans in the United Kingdom, on the other hand, are funded in much the same way as Canadian private plans, but the relationship between public and private plans is very different from that in Canada. Private plans in Great Britain can contract out of the public scheme provided the plan is at least as good as the public scheme. A very interesting aspect of this system is that the private plan members continue to contribute to the public scheme, but at a reduced rate, and the government picks up the tab for inflation protection.

I was particularly happy to get a first hand look at pensions in Sweden because of the striking similarities in the systems of our two countries. Like us, they have a universal,



residence-based pension, a compulsory earnings-related public scheme based on contributions, and also a system of private pension plans. The clearest difference is one of scale - for example, their earnings-related public plan covers a much higher level of earnings, replaces a higher percentage of pre-retirement income, and has a larger fund than the Canada Pension Plan. Another example is the fact that private plans cover 90 percent of workers in Sweden, which is almost double the private plan coverage in Canada.

I was also very interested in their more gradual approach to retirement. There is, in Sweden, a partial retirement program which enables workers to move from full to part-time work after age 60 with only a minimal reduction in their income. This helps to avoid the shock of the abrupt retirement which is the general practice in Canada. It can also be an advantage to both the employer and the employees in offering an alternative to sudden layoffs or costly early retirement plans.

Another thing which I found of interest in the Swedish system is the way in which they invest part of the surplus of their public pension funds in the private sector. These investments are in the hands of a board made up of representatives of employers and labour which operates at arms' length from the government. There are certain rules regulating these investments - for example, the company must be Swedish and the total amount of stock of any one company that can be held by the pension fund is limited. As well, the fund can't invest in banks or insurance companies. I was told that the pension fund is an important source of investment capital in the Swedish economy.

One thing that struck me particularly was the size of the investment made in the pension system in each of these four countries. In Germany, for example, the public plan is supported by a contribution of 18 percent of payroll, 9 percent paid by the

employees and 9 percent by employers. Any contributions to a private plan must, of course, be added to this cost. Comparable levels of contributions apply in the other three countries. In Sweden, the public plans are financed by some 20 percent of payroll, with additional percentage points for the private plans, all paid entirely by the employer.

Compare this with our 3.6 percent contribution rate for CPP. Even taking into account the taxes paid to support OAS, and the private plan contributions (generally only a very few percentage points) paid by roughly half of our work force, our contribution to pensions is small related to these European countries.

Don't get me wrong. I am not proposing that we should adopt their levels of contribution. But I am suggesting that we can afford to make provision for adequate retirement incomes in Canada. We may be having a few problems at the moment. But pensions are a long-term matter. And consider the enormous future potential of this fortunate country to which we belong. Let us take the optimistic view. Let us not be timid in seeking solutions to the pension problems now before us. Canada can and will provide a decent living to its senior citizens.

Now, I am not suggesting that we can expect to find ready-made answers to our pension problems simply by looking at the experience of other countries, any more than we can expect to find them ready-made here at this Conference. But we can learn some very important things in both cases.

The first is that the problems we face are not insurmountable or unique. Other people have faced the same difficulties and have found ways to cope. And there is every reason to believe that Canadians can do at least as well.

Secondly, by adopting a flexible attitude in examining the ideas and experiences of others we have a greater chance of finding the solutions that are appropriate for us.

And thirdly, we have no reason to fear the future if we get to work now, to create the kind of system we will need in the years to come.

I don't wish to leave the impression that our answers lie in scrapping the system we have in place and adopting some other approach simply because it has worked well elsewhere. On the contrary, what I have seen in other countries and what I have seen right here at this Conference has convinced me that the answers can and must be found right here and must be based on the social, political and economic structures that Canadians have worked so hard to create and maintain.

If I may add one final remark, I would like to say that this National Pensions Conference is a most important event for me, personally. Ever since I first became Minister of National Health and Welfare, one of my highest priorities has been to attempt to provide the assurance of a decent standard of living to our senior citizens. We have made some significant improvements to the Guaranteed Income Supplement program. But this Conference, I hope, will mark the beginning of a fundamental decision-making process which will ensure the achievement of that important goal - a life of comfort and dignity in retirement for all Canadians.

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l'honorable Monique Bégin

Office of the Minister  
The Honourable Monique Bégin

NOTES FOR AN ADDRESS

BY

THE HONOURABLE MONIQUE BÉGIN

TO THE

HAMILTON BUSINESS AND PROFESSIONAL

WOMEN'S CLUB LUNCHEON

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I was very pleased and honoured to be asked to speak at your International luncheon today. The Canadian Federation of Business and Professional Women's Clubs has a long and respected tradition of involvement in the important social issues of our times. It is a tradition which owes much to the inspiration and the tireless work of Elsie Gregory MacGill, a great Canadian whose recent loss was felt very deeply by me and, I am sure, by all of you who knew her or knew of her.

I think that Elsie would have had a particular interest in the issue which is the highest social policy priority of the federal government today: pension reform. The National Pensions Conference which took place last week marked the beginning of a new phase in pension reform - a phase in which we put study and talk behind us, as we move into action.

The Prime Minister stated the call for action clearly in his remarks opening the Conference. He said, and I quote, "we are determined to bring about substantial pension reform during the present mandate. We would hope that the provincial governments will agree to meet with us in July, to refine the objectives together, to learn more about provincial points of view, and to begin to work out ways in which Canada and the provinces will jointly implement pension reform."

For women in particular, the benefits of pension reform could be enormous, because it is women who suffer most from the inadequacies of the existing pension system. However, women will only realize these benefits if they take a strong role in the public discussions on pension issues. Louise Dulude, in her just-published study "Pension Reform with Women in Mind" which she prepared for the Canadian Advisory Council on the Status of Women, speaks of the need to "feminize" the pension debate. I agree. This debate must represent the points of view and the interests of both women and men. This is where your Club, and all the other Clubs in your Federation, can play such an important part.

What I would like to do today is to review with you what has been accomplished so far in pension reform, where the remaining problems lie, and where we hope to go from here.

Canada has a retirement income system that is made up of three layers (or, as my officials like to call them, three tiers). The foundation of this system is the universal Old Age Security program. It assures every Canadian aged 65 or over a basic pension of \$208.20 a month, and this amount is increased four times a year in accordance with the rise of the Consumer Price Index. For someone who had earned the average industrial wage, the Old Age Security benefit replaces about 15 percent of her (or his) previous earnings. I might note that since elderly women outnumber elderly men, this program does benefit women more than men.

On top of the Old Age Security pension, there is the Guaranteed Income Supplement which was introduced in 1967 by the federal government to provide an additional source of income for pensioners who had little money other than from the OAS. The combination of Old Age Security and Guaranteed Income Supplement ensure all single pensioners a monthly income of at least \$417.23. For a married couple the monthly "guarantee" is \$738.72.

Fifty-four percent of all Old Age Security pensioners receive benefits from the Guaranteed Income Supplement. In other words, 54 percent of all our pensioners are on a kind of welfare. There is another statistic that I want to share with you. Of the 1 166 000 GIS recipients in 1980, 706 000 - over 60 percent - were women. That figure speaks for itself.

The second layer of Canada's pension system is made up of the Canada Pension Plan and the Régime de rentes du Québec. With the introduction of these plans in 1966, all Canadians in the paid labour force were given the chance to contribute a percentage of their earnings to a pension plan. The maximum

Canada Pension Plan benefits on retirement is now \$274.31 a month. This year more than ten million people will contribute to the Canada Pension Plan or the Régime de rentes du Québec.

When the Canada and the Quebec Pension Plans fully mature, they will replace 25 percent of the average wage. Combined with the Old Age Security pension that I spoke of a moment ago, this means that the public programs protect approximately 40 percent of the income of someone who has worked at the average wage.

Obviously this is not enough to prevent many Canadians from experiencing a drastic drop in income at retirement. For middle-income Canadians in particular, it can mean almost certain hardship, unless they have some other source of income.

Of course, Old Age Security and the Canada Pension Plan were never meant to be all that pensioners would want or need in the way of a retirement income. The system was designed to leave room for a third layer of pension income - income from company pensions and personal savings. This is where most of the problems with the existing pension system lie.

The last few years have produced a large array of reports on pension issues. These have come from government, from research institutes, from the private sector and from organizations such as your own. At the same time, the federal government has made some significant improvements to our own public programs. Women have especially benefited from these improvements.

There have been two major increases to the Guaranteed Income Supplement - a \$20 a month increase in January 1979 and a further \$35 increase in July 1980. Of course, these have been on top of the regular quarterly indexation. These increases have very significantly improved the income protection of the large number of elderly women who must rely on the Old Age Security and the Guaranteed Income Supplement as their sole or their major



of income. Currently, benefits from these federal programs guarantee a couple an income just above the poverty line. For single persons, though, the guarantee is still short of the poverty line - in fact, only 86 percent of the poverty line.

We know that this is not good enough, and that there must be further improvement to bring all single persons receiving the Guaranteed Income Supplement up to the poverty line. As the Prime Minister said at the National Pensions Conference, "we must ensure that these people, who have no other resources, can live in health and dignity." I was pleased to see that the Canadian Federation of Business and Professional Women's Clubs, in your 1981 brief to the federal government, urged us "to increase the Guaranteed Income Supplement without delay to make it equal to the Statistics Canada poverty line". This same view was expressed by virtually all the speakers at the National Pensions Conference. You have my pledge that, as soon as economic conditions permit, I intend to go to Cabinet with a request for such an increase. It is my highest priority, and it will be done.

Another area in which the federal government has made major improvements to public programs with the goal of fairer treatment for women, has been in the Canada Pension Plan. It is a tribute to the work of your group, and others who pressured for reform of the Canada Pension Plan, that women are now eligible for the same benefits and provisions of the Plan as men. Among the most recent developments has been the inclusion in the Canada and Quebec Pension Plans of women working in family businesses.

An important measure in the Canada Pension Plan which would benefit women significantly is the so-called "child-rearing drop-out" provision. At the present time, the amount of retirement pension from the CPP to which a person is entitled is based on her or his average earnings between 18 and 65 years of age. The fact that the majority of women have years of low or no earnings when they leave the labor force to raise their families can result in a drastic reduction to their pensions.



In 1977 Parliament voted to amend the Canada Pension Plan to protect the rights of contributors who leave the labor force to raise children. In effect, mothers with children aged less than 7 would not have to count those years of low or no earnings in calculating their entitlement to retirement benefits. It has been estimated that this drop-out provision would raise the average retirement benefit of a mother with children by 22 percent. This is clearly a significant gain for the more than two million married women in the paid labor force.

Unfortunately, this amendment did not receive the required provincial approval because of Ontario's veto. The Canada Pension Plan Act requires the consent of two-thirds of the provinces with two-thirds of the Canadian population before such a major change can come into force. This gives Ontario a veto. I might add that a similar provision has been in effect in the Quebec Pension Plan for several years.

When Parliament approved the drop-out provision in 1977, the Ontario government said that it wanted to hear the views of its Royal Commission on Pensions before it gave its OK. The Royal Commission has now given its views. It has said that the drop-out provision should be implemented without delay. I've heard it said that during the recent election campaign Ontario was waiting for someone to "demand" implementation of the provision, and that the province would then rapidly give its approval. However, the story goes, no one made the demand so Ontario didn't act. If this is true, it would be a truly strange way of handling a matter of public policy that is central to the concerns of women. But be that as it may, I would urge all of you now to make your views on this matter known to your provincial government. And try to get other women's groups to do the same. I was very encouraged by the widespread support for the drop-out provision expressed at the National Women's Conference. I think that this is definitely a gain which women can achieve in the very near future.

Another recent change to the Canada Pension Plan that benefits women is the splitting of CPP credits between spouses in the event of divorce. Unfortunately, very few people have taken advantage of this provision, in spite of extensive efforts by my Department to inform Canadians. I would ask all of you to help me make it better known.

I know that when I speak of the Canada Pension Plan, one of the first things that comes to your mind is the question of pension protection for women who work in the home. Of the approximately five million married women in this country, some three million fall into this category. Few have any personal pension protection at the present time except from the Old Age Security program. Clearly something must be done for them.

There is no easy solution to the problem. While I have not put forward specific proposals or policy statements in this regard, I have raised the issue on many occasions and I have outlined various possible measures to remedy the problem.

One approach would be to allow voluntary contributions to the Canada Pension Plan. Levels of contributions could range from some minimum amount up to the maximum contribution currently allowed for self-employed persons. At most it would involve payments at 1981 rates of \$40 a month, assuming that the voluntary contributor would have to pay both the "employee's" and the "employer's" share, like a self-employed person.

Certainly there are problems associated with a voluntary contribution scheme. For example, how would we collect the money? What would happen to those who are in the labor force, but who make less than the maximum that might be permitted for voluntary contribution? Would we require contributions on earnings and permit voluntary "top-up" contributions? Where would persons working in the home get the money to make voluntary contributions? Needless to say, I am particularly concerned that those women from low-income families who would be in greatest need for extra retirement income would be least able to afford the contributions.

However, I am convinced that a just and workable solution can be found. I can give you my personal assurance that we will examine every possible option in that search.

We have come a long way since 1927 when the first federal old age pension was introduced, and in the most recent years there has been considerable refining of the pension system. However, the facts are that close to one-third of this country's aged live in poverty, and most of these citizens are women.

The shortcomings of the private pension system have been singled out time and time again. Private pension plans provide inadequate coverage, often no portability, little or no indexing, and insufficient survivors' benefits. These inadequacies affect all workers, but the point is that every one of these shortcomings hit women worse than men.

The first point is that only 34 percent of the female labour force is covered by employee-sponsored plans. This should not surprise us. Women have more limited access to pension plans because a good many of them are trapped in jobs earning a minimum wage and no benefits or they are forced into part-time jobs seldom covered by company pensions.

Furthermore, belonging to a company plan does not guarantee the receipt of benefits in retirement. Most pensions are not portable and, since full vesting is usually limited to plan members with at least 10 years of service, they can neither be taken with the employee nor left with the employer when she changes jobs.

The current vesting provisions particularly discriminate against women who so often leave their jobs when they start a family. Since the average age at which women have their first child is in the early 20's, it is extremely unlikely that the vast majority will have worked for the same employer for 10 years nor, obviously, will they have attained the age of 45, which is often required for full vesting.

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Inflation has devastating effects for women who tend to have smaller pensions and to live longer in retirement than men. Employer-sponsored plans have been extremely reluctant to provide meaningful protection to pensioners. Without some adjustment for inflation, a person retiring in 1971 with a fixed annual \$2000 pension would have seen its purchasing power halved by 1980.

It is clear that the current system of private pensions presents great difficulties to women attempting to build up credits toward an adequate retirement pension. The importance of this is often minimized in the belief, still prevalent, that women will always be financially taken care of by fathers or husbands. Women can no longer count on the lifetime support of a husband. It has been estimated that only one in four women in this country can expect to live with their husband until death due to their longer life expectancy and the rising divorce rate.

Nor can women count on a fair share of their family's accumulated assets. In the case of women left alone by the death of a spouse, only 35 percent of private sector pension plans provide survivor benefits. Since only 50 percent of men are currently members of employer-sponsored plans and entitlement to survivor benefits tends also to be conditional on years of marriage and years of service, the chance of a wife receiving survivor benefits on the death of her husband could be as low as one in five.

At divorce, a spouse who may have worked exclusively in the home generally loses all entitlement to pension benefits that have been accumulated by the earner during the marriage. There is no pension credit-splitting provisions in private plans as there is now in the Canada/Quebec Pension Plan. The exceptions are in British Columbia where people who separate or divorce are entitled as of right to a half share in the employer-sponsored pension credits or benefits and in Quebec where pension rights with an immediate cash value are shareable equally upon marriage breakdown.



Women and pensions was one of the four major issues examined at the National Pensions Conference. This Conference brought together representatives of all sectors of society - federal and provincial governments, workers, pension plans sponsors, pension suppliers, research institutes, social interest groups, individual experts and, of course, women's groups. The Conference had two objectives: first, to raise the awareness among Canadians of the problems in our pension system and second to discuss the extent to which reform in private pensions is likely to meet the needs of Canadians for improved retirement incomes.

While the federal government is just beginning the complex process of assessing the results of the Conference and developing a policy position on pension reform, I can say that all signs were very encouraging. No one failed to recognize the special problems faced by women saving for retirement and the need to act to prevent future generations of women from experiencing poverty in retirement. More specifically there was broad acceptance of the need to extend coverage to more Canadian workers, to improving vesting and locking-in provisions and the portability of pensions in general, and to ensure protection of deferred pensions against inflation - measures that will improve the ability of women workers to accumulate pension credits. There was strong support for extending survivor benefits and a recognition of the problem that an increasing number of divorces is creating for women working in the home. Of course there were divergences on how some of these measures could best be accomplished. However, on balance, there appeared to be powerful consensus for reform. Indeed, many representatives of women's organizations must be congratulated in this regard for their work in putting the issues before the delegates and in conveying the sense of urgency and seriousness that accompany these issues.

One of the interesting suggestions that came forward is for a further series of regional conferences to examine specifically the many complex issues of women and pensions. While I think that the time for conferences and studies on most aspects of pension reform is past, the women's and pensions' question is one on which I think regional conferences could be useful. I would certainly welcome the views of women's groups on this.

For women, the agenda for reform of the retirement income system is lengthy. Developments in any one of the areas I have mentioned today could significantly improve the welfare of the coming generations of women. But much will depend on women keeping their concerns known. I certainly intend to do my part.

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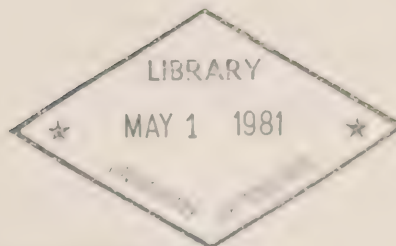
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The Honourable Monique Begin



NOTES FOR AN ADDRESS

BY

THE HONOURABLE MONIQUE BÉGIN

AT THE

1ST NATIONAL CONFERENCE ON CHILDHOOD

ACCIDENTS AND PREVENTION

APRIL 14, 1981





Ladies and Gentlemen, at the outset let me thank the convenors of this Conference for inviting me to open the meeting with a few words about child safety. Childhood accidents have been called the "Silent Epidemic of Modern Society". Other problems which have a relatively minor impact on health often receive far more attention. I hope that the delegates to this Conference will do all they can to ensure that the issue of child safety does not remain a silent one. The range of interests represented here today attests to the importance you all attach to the subject and I hope the Conference serves as a springboard for some concerted national action to reduce the number of childhood accidents.

A brief look at our record of childhood accidents indicates action is long overdue. Accident rates for children and youth in Canada are higher than in most western countries. In 1974 Canada had the worst record of accidents among 18 countries in the 5-14 age group, and rated only slightly better in the 1-14 age group. In 1978 there were 6 516 children aged 14 years and under who died in Canada. Of these, 1 420 or 22 per cent died as a result of accidents, poisonings, and violence.

Next to traffic accidents, the home is where most of fatal accidents occur with falls, burns, poison ingestion and crib deaths due to strangulation as the major causes. Most people are aware of the effectiveness of detergents, bleaches, birth control pills, insecticides, polishes, solvents, aspirins, disinfectants and hundreds of other common household items when they are used for their intended purpose. What they often forget is that drugs, medications, cleaners, petroleum products and even plants are potentially dangerous to young children.

Parents do not deliberately shop for poisons, yet almost everytime they go to the supermarket they buy them. The average household has as many as 250 of these poisons in bathrooms, under kitchen sinks, in purses, closets, drawers and living rooms, on dressing tables, in basements, garages and trunks of cars.

Most of these places are within easy reach of small children, the same children who are the highest risk for accidental poisoning.

Accidents do not "just happen". I am sure this is a truism for most people present here today, but it is a message that needs extensive and constant promotion. We must build more safety into the environments in which our most vulnerable citizens live. Passive protection is not enough. More parents need to be made aware, through education that accidents represent the greatest threat to their children's health.

I believe this education of parents should start even before the child is born. Pregnant women should be advised by their physicians to wear seat belts throughout their pregnancy. Mothers and fathers should be told that beginning with the trip home from the hospital, the baby should always travel in an infant restraint system.

Physicians and Public Health personnel have an important and continuing role in explaining to their patients the importance of good design in babies' cribs, playpens and toys. While avoiding the use of undue fear tactics, we must convince parents that providing children with an environment free of unnecessary hazards may accomplish more than any other health care measure. While parents have the prime responsibility for their children, they must be well informed and alerted to possible dangers so that they can provide the first line of defence because, the home environment - which should be the most secure, can also be one of the most life-threatening.

Children are curious and exploring is an important part of growing up. But as soon as possible they must be taught to understand the risks they face.

Recently, I read a tragic story of a 4-year-old girl who was warned by her mother that if she crossed the street, she would be spanked. Instead of looking for oncoming traffic, she walked into the street looking back over her shoulder to see if her mother was watching and did not see the car that struck her.

She had not been warned "if you go into the street you may be hit by a car". She had only worried about the spanking.

Parents must be encouraged to protect their children by such measures as buying stoves with out-of-reach controls, covering electric outlets, locking medicine cabinets, surrounding pools with child-proof fences, not have firearms in the home, padding play area surfaces, and not buying potentially dangerous toys.

Growing up is a risky business but this does not mean we adults cannot do something to reduce the risks children face.

I believe a great deal is already being done by the corporate, governmental and voluntary sectors of Canada. If this were not so, this Conference would not have been held. I am pleased that my Department is participating and was able, through the newly established Health Promotion Contributions Fund, to cofund it. However, if we were to answer the challenge set by the title of this Conference "What can we do better"? we must do more. We all have a role to play. This includes automobile manufacturers designing measures to increase the safety of children, marketers promoting the advantages of safe cars to make their purchase appealing, and health professionals who can do much to reduce childhood injury through counselling and education.

All of us have a role as educators to continue our efforts to ensure that Canadian children are provided with sound instruction in safety practices; to make sure that parents are well informed of proper safety practices; and, that the general public is able to practice sound first aid and rescue practices with accident victims. Voluntary groups and agencies who have for so long "carried the flag" deserve our support in their continued efforts to promote safety. The mass media can play a major role in producing programmes to show safety practices as a way of life which should be followed in the home and at play.



I also believe that governments at all levels can play a lead role in passing legislation to protect the public from injury. Seatbelts legislation has proven to be the single most effective means of reducing injuries and fatalities resulting from automobile accidents. Governments also can develop standards of consumer safety; provide information and materials on public safety practices; and support research communities, voluntary agencies and public interest groups in their work in injury prevention.

At the federal level a number of departments are involved in child safety programmes, particularly Consumer and Corporate Affairs and Transport Canada. My Department, through its cheque insert programme, recently collaborated with Consumer and Corporate Affairs to bring information about safety to all parents. We need more collaborative efforts of this kind. As many of you know, sometime ago accidents were identified in the New Perspectives on the Health of Canadians as an important and preventable aspect of our modern "lifestyle". We have been able to formulate national goals and specific strategies aimed at reducing the toll of home and recreational accidents by 10 percent by 1985. To collectively meet this goal in Canada will require the active participation of provinces, professions, voluntary groups and the corporate sector.

We share a common goal and that is to find ways to ensure that our children can grow and develop free from injury and death. This is a priority identified by Canada's International Year of the Child Commission. In terms of prevention of handicap, it is also a priority of this, the International Year of Disabled Persons.

To see the fruits of prevention in the long term, we are going to need committed health professionals, strong voluntary organizations and an informed and motivated public.



You have the opportunity in this Conference to send some strong messages and direction to all Canadians to make child safety a "way of life". In the words of the ancient prophet "Who shall prepare for battle if the trumpet gives an uncertain sound?". I look forward to hearing clear and certain sounds.





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NOTES FOR AN ADDRESS BY THE  
HONOURABLE MONIQUE BÉGIN  
TO THE  
34TH WORLD HEALTH ASSEMBLY  
GENEVA, MAY 7, 1981





Madam President, Dr. Mahler, honoured delegates and observers, ladies and gentlemen,

Madam President, to you and to the other officers of this 34th World Health Assembly, I extend my warmest personal congratulations and those of my delegation, on your election. We have great confidence that you will guide us to conclusions that will contribute to the objectives which the world community seeks in matters of international health.

I welcome this opportunity to address the 34th World Health Assembly on behalf of the people of Canada. I shall use the occasion to bring to your attention my country's views on current health issues and on the work of this great Organization.

Over 150 countries have gathered here to pursue an overriding objective - Health for All by the Year 2000. Some may say we are pursuing an impossible dream or that the goal is meaningless because of the gross inequalities in the health conditions of different countries and different populations within the individual countries. It is up to us to prove that they are wrong.

WHO has had two significant accomplishments in the past decade - the declaration of Alma Ata established primary health care as the key to universal health. This Assembly then resolved that we shall set for ourselves the target of attainment by all the people of the world of a state of health that will permit them to enjoy social and economic progress, by the year 2000. The attainment of this objective is not solely the responsibility of the individual, but rather society, including governments and other organizations must help to change values and lifestyles.

The translation of primary health care strategies into relevant terms for countries with high standards of living and well-established health care systems, is a unique challenge. I am pleased to note that the European Region, in its regional strategies document has emphasized the lifestyle approach, first proposed in a document "a New Perspective on the Health of

Canadians". We in Canada had concluded that traditional approaches based on high technology, were no longer contributing to continuing improvement in health conditions. Instead, greater priority had to be given to preventive measures relating to the environment and to public information and education, so as to deal with causes of modern health problems.

At the same time, many countries still experience health conditions of a more fundamental character. Their representatives here may feel that health protection and promotion are luxuries they can ill afford. I cannot agree - the fact remains that self-induced disease and trauma affect people in all walks of life. Indeed, dysfunctional lifestyles may have even greater impact in developing countries and therefore are perhaps even more important in the saving of human lives and the reduction of human suffering.

Madam President, the global strategy for health for all document, before us for consideration and approval, is written in terms broad enough to encompass a wide range of political and health care delivery systems. The health and socioeconomic policy section is sufficiently general to be applicable to the specific health needs of individual nations.

For Canada, the goal of health for all by the year 2000 will involve concerted action between the federal government and the governments of the provinces. Provinces have the primary responsibility for the provision and delivery of health services. Both levels of governments, however, have roles to play in health promotion, protection, and prevention, research and financing of health systems. The WHO strategy provides us with an excellent blueprint for this cooperative action.

Madam President, many of Canada's health problems do not differ greatly from those of other developed countries. We recognize that health and socioeconomic development are



intrinsically linked. Consequently, the focus of our social policy is on the elimination of poverty and the promotion of economic development. We want Canadians to have more equal opportunities to enjoy healthy and productive lives.

In Canada, problems of urban poverty are a growing challenge. More and more people migrate to large cities in search of employment. The health and socioeconomic development of our Indian and Inuit peoples, many of whom live in small isolated northern communities, must equally be of high priority. They experience a high incidence of gastroenteritis, respiratory diseases, alcoholism and accidental death. The Government encourages greater involvement and participation by Indian people in decision making and programme delivery, affecting their development.

We are also concerned about the high rate of preventable deaths, diseases and accidents. We agree with the Director General, Dr. Mahler, that "more than ever before, the solution to today's health problems depends on what people do or do not do for themselves". Traffic accidents, heart disease, lung cancer and breast cancer take a heavy toll of human life in Canada. Drinking, smoking, poor eating habits, stress and lack of proper exercise all contribute to these major killers, either singly or in combination.

Madam President, these killers could be held in check to a greater or lesser degree by a change in lifestyle. I am convinced that the greatest challenge facing the health professions today is to convince the public to change habits and behaviours that shorten lives and affect health. In Canada, federal and provincial programmes are directed specifically to certain of these problems. Such programmes include: Dialogue on Drinking - Operation Lifestyle - Participation - Canada's Food Guide -

and our most recent endeavours, Generation of non-smokers and a nutrition programme called - Balance. Canada, of course, is willing to share its experience in health promotion with other countries.

Indeed, Madam President, while "Health for all by the Year 2000" involves principally movement at the national level, by means of government policy commitments and the mobilization and reallocation of domestic resources, it also provides uniquely for cooperation among all countries, developed and developing. The sharing of experience is perhaps the most important form this cooperation will take, but certain countries - the least developed - require the support of the international community if they are to put their own scarce resources to best use. In recognition of this, Canada, the WHO and certain African governments have already joined to produce "Santé Afrique", a project for the dissemination of film material on primary health care particularly suited to community health needs in French-speaking Africa. I know that we and others will find further occasion for this sort of support, which is essential if our common objective is to be realized everywhere.

Madam President, the Draft International Code of Marketing of Breast Milk Substitutes deserves special mention. The carrying out of the 33rd World Health Assembly resolution on this subject has been a long and arduous task. But we now have before us a draft code which, I believe, meets our purposes.

Because of its importance to healthy infant growth and development, Canada is strongly committed to the promotion of breast feeding and to the creation of an environment supportive of breast feeding in the home and elsewhere. The Assembly resolution and the Draft Code have served to raise the level of awareness of Canadians. There has been a great deal of discussion within the industrial and private sectors concerning not only the advantages of breast feeding, but also the serious

infant health problems that arise when breast milk substitutes are misused. Canadian programmes over the past decade have resulted in a doubling of the percentage of mothers who breast feed, and this figure is now over 50 percent.

Madam President, I wish to reaffirm Canada's commitment to breast feeding and our support for the position taken by the executive board on this issue.

Madam President, I should like to turn to a topic of growing concern to all of us in times of inflation and economic instability. I refer, of course, to the rising cost of delivering health programmes and services from which no country represented at this Assembly is exempt. Canada spends 7.1 percent of its GNP on health - a reasonable proportion in my view. Rather than utilizing resources almost exclusively on treatment facilities and technological expertise, there is greater need today for the development of:

- Community health, with particular emphasis on individual involvement
- Care of the aged and infirm
- Health promotion and prevention.

There are within the spectrum of health care, possibilities of an optimum combination of treatment and prevention for each country.

Within the WHO, I think it is the duty of the Assembly to ensure that health programs develop and are implemented for those who are in greatest need - that full use is made of local resources and that skills and technology utilized are both appropriate to and effective in relieving priority health conditions. The task is formidable, but I am confident that, working together, we will succeed in achieving "Health for All by the Year 2000".

In conclusion, Madam President, I want to extend best wishes to the Director General, Dr. Mahler. I want to commend him for his unfailing leadership. I want especially to recognize in this Assembly the enormous personal effort he has made to give substance and meaning to "Health for All by the Year 2000".

Thank you Ma'am President.

Age Group	Percentage
18-24	85%
25-34	75%
35-44	65%
45-54	55%
55-64	45%
65-74	35%
75-84	25%
85+	10%



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NOTES FOR AN ADDRESS

BY

THE HONOURABLE MONIQUE BÉGIN

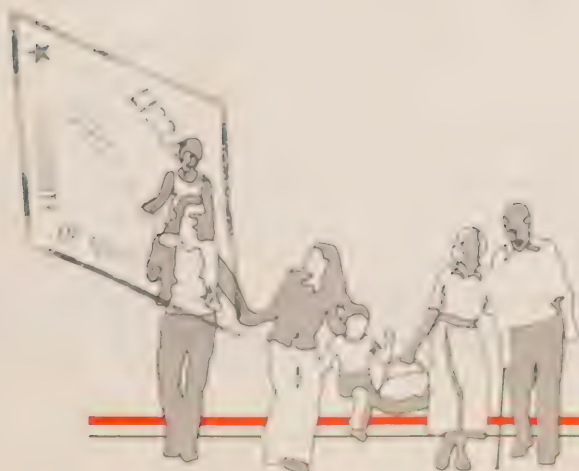
TO THE

1981 ANNUAL SCIENTIFIC ASSEMBLY

OF THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

CHATEAU FRONTENAC, QUEBEC

May 13, 1981







At your kind invitation I am here to achieve two things. First, to offer a few comments on the theme of this Assembly, "Preventive Medicine - Fact or Fiction". And second, to challenge each of you to accept greater responsibility for the practice of preventive medicine.

Given my challenge to you, it should be clear where I stand on your theme. Preventive medicine is not, and cannot be permitted to become, a fiction. I believe that every Canadian could reasonably expect to experience optimal health throughout his or her lifetime. However, this expectation will not be realized by individual efforts alone. Our national health care system must support the efforts of our citizens. Therefore, I appeal to you, being within the system, to make preventive medicine a fact of health care in Canada.

Before I proceed further, I want to digress a little to publicly acknowledge your contribution to the evolution of prevention as a major endeavour of contemporary medicine and to commend you for it.

Your choice of family medicine tells me much about your approach to health. You are concerned with individuals and their families as a whole rather than the treatment of an illness as an isolated event. May I suggest that no one, outside of your patients and their families, is in a better position than yourselves to fully understand and, in some sense, experience the suffering of illness and the joy of health. You are in the ideal position in primary and secondary care to not only cure, but to foresee and prevent illness.

It is not surprising, therefore, to find family practitioners at the leading edge of the movement toward preventive medicine, health maintenance and promotion. The theme of this Assembly testifies to your interest in prevention. Your journal The Canadian Family Physician gives prevention high priority, including its special section on prevention in the March number.

If we are to reach the World Health Organization goal of "Health for All by the Year 2000", then I think we will need many more of you.

I come now to my first challenge. What are you and your College doing to achieve this goal for Canadians? Can Canadians look forward to concerted initiatives by their family doctors to maintain health? Do you look upon yourselves as leading your colleagues in medicine, nursing, pharmacy, radiology, physiotherapy, psychology and social work in taking aim on the goal? Do my fellow ministers of health and I have a role that we are not playing?

Being on the front line as primary health care workers, I expect you to be asking yourselves questions like these. And I have every confidence that your answers will be insightful bases for innovative action. I also have every confidence that you will come up with some very pointed questions of me and my Department. Well, let me hear them. In giving yourself direction, give me direction on what we as a nation can do.

My officials and myself may have to be ready to deal with some tough questions. But, I think it's in the game and we should be prepared to face them.

My second challenge is to ask you to pause and consider what "prevention" means in your practice. Does an attitude of preventive medicine permeate your work, and that of your co-workers? Almost every clinical encounter provides an opportunity to prevent illness and promote health. Are you seizing these opportunities? If so, I commend your medical expertise as most precious. Surely prevention is not as gratifying as treatment. Its value is seldom demonstrable in the short run.

On the other hand I wonder why immunization rates are not what they should be. Or, why so few smokers report that their doctors have counselled cessation. Or, why Canadian diets are

saturated with salt, sugar, fats and junk foods. Or, why those who have problems with alcohol often have to knock on seven or eight doors before they obtain help with their problems. Is it not an important role for the family physician to be aware of the individual susceptibilities of the patient and to provide counsel on what environmental agents should be avoided?

Now, I am not arguing that family doctors are responsible for letting these concerns slip by without attention. However, I do want to ask you to make prevention such a part of the care you offer that fewer and fewer do slip by.

For each of us the maintenance of health is a life-long activity. It is a matter of being healthy today and planning to be healthy tomorrow.

My third challenge to you is to help us and your patients, to plan our health. To know, and make known to us, the important causes of illness throughout the life cycle. We also need to know how to prevent these illnesses.

Are you, and the families you serve, aware that accidents are the most important causes of death and disability among children, and that most are preventable? Are you and your patients surprised that suicide is the second most frequent cause of death among young men and women? Does it surprise you and your patients that diseases "of indulgence" such as heart attack, strokes, lung cancer and cirrhosis of the liver have become the leading causes of mortality and morbidity in middle age? Are you and your women patients concerned about screening for breast cancer?

My point is that preventive medicine is inherently futuristic. What you and your patients do today can determine their health and quality of life for years to come. Knowing what tomorrow may bring your patient arms you with the foresight to caution, counsel and examine accordingly, and thus to equip your patients to maintain their health.

This is the International Year of Disabled Persons. An objective of almost all nations of the world is to "normalize" the lives of their disabled.

My fourth challenge to you is to become exemplars for us all in assisting the disabled to escape or limit the medicalization of their lives, and in supporting their efforts at independent living. A very large portion of the disabled want to and can enter the mainstream of life. But, we have to help equip them to manage their lives, rather than medicate them into states of apathy. We need to encourage their aspirations, not foster apprehension. We have to see "ability" where for too long we have seen disability.

Your vocation places you in an ideal position to help us all, but particularly families, in coming to terms with handicap. You can help us all to go beyond the adversity of the moment, and the fear of the future, to optimistically encourage full development of the capacities of the handicapped. One example of the way in which families may be assisted, and the patient may benefit is the infant stimulation type of program offered to children with developmental delays or disabilities.

These programs build on abilities, refuse to accept present limitations as indicative of true capacity, and mobilize the strengths of the child and its family. I encourage you to learn more about infant stimulation programs.

My final challenge to you, and it is the most basic of challenges, is to recognize and develop your power as motivators. We Canadians retain a high degree of trust and confidence in our doctors. The Canada Health Survey found that in 1978-79 three of four Canadians had consulted a doctor at least once in the previous year. Of these, one third had consulted their doctors three or more times. Clearly, you have an opportunity for face-to-face contact with a large proportion of the population every year.



As our appreciation of the importance of life-style to health has increased, there has been a tendency to assert that individuals are responsible for their health, or illness. However, this does not mean that people should be left to their own devices. They need to be informed, advised, persuaded and equipped to take action on their own behalf, that of their families, and their communities. You are in ideal positions to meet these needs.

Help your patients understand what is going on in their bodies - why is their blood pressure important, how can they keep cholesterol levels down, what are the effects of drugs, be they alcohol, tobacco, coffee or prescribed or over-the-counter preparations?

Women have special concerns that must be understood to be acted upon. Tranquilizing these concerns is not a route to health. I understand that the College is of a similar mind. The elderly seem to have become major consumers of medications. And we all know the danger of too many drugs to older patients, their facility to forget the proper dosage, their negligence in mentioning other drugs that they take and the difficulty for them to observe and report the adverse reactions. What a tragedy it will be if our parents and grandparents end up living out their lives dependent upon drugs.

Motivate personal understanding of health, and of the ways to maintain it. Motivate changes in nutrition, in tobacco, alcohol and drug use, in exercise, in interpersonal relationship, and in self-care! Your power as motivators may be the most fundamental tool in the practice of preventive medicine.

But, I also challenge you to turn your powers of motivation on decision-makers. Advocate the benefits of preventive medicine within your profession. Advocate greater attention to prevention and care in the community, rather than institutions. Advocate

community action to reduce the hazards of personal habits and environments in your town or city. Pressure me and other politicians to deal with key health issues. Advances in health require political action at both formal and informal levels.

Ladies and gentlemen, do not underestimate your role. Do not underestimate your power to have things changed. In the way you think, in the way you practise medicine, and in the way you influence the health care system - you can determine whether preventive medicine is fact or fiction. My challenge to you is, make preventive medicine a constant fact in your own mind and preach it to your fellow professionals and to your patients.

Thank you for having me with you. Your actions are regarded as of the utmost importance to the health care of the nation.

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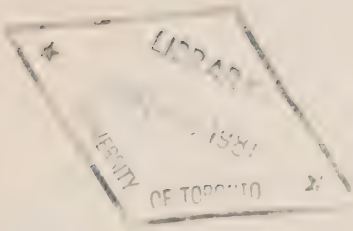


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NOTES FOR AN ADDRESS

BY

THE HONOURABLE MONIQUE BÉGIN

TO THE

CANADIAN NATIONAL INSTITUTE FOR THE BLIND

TORONTO, ONTARIO

May 14, 1981





Last winter I had the honour to officially open White Cane Week on behalf of the Ottawa Division of the Canadian National Institute for the Blind and the Canadian Council of the Blind. This gave me an opportunity to see the CNIB in action at the local level and it is a great pleasure to be in Toronto today for your national meeting.

As the federal minister responsible for the International Year of Disabled Persons, I have a particular interest in seeing that the expectations of your members and those of all other Canadians with special needs are met. The enthusiasm with which the two million disabled Canadians have taken up their own cause and the support they are being given by the public convinces me this will happen.

This climate of goodwill is making it much easier to introduce specific measures on behalf of the disabled. Some of the measures needed will be costly and complex - none more so than solutions to the first and foremost problem facing the disabled. That is, to ensure them an adequate income.

I realize that, like all Canadians, the disabled would prefer an income to come from a job. To this end, the Minister of Employment and Immigration has introduced an experimental program of wage subsidies to help the private sector hire disabled persons. This program is estimated to cost \$25 million in the present fiscal year, and \$34 million in the next year. It is expected to place 2300 handicapped and 4600 employment-disadvantaged Canadians in permanent jobs in the private sector. The program includes both phased wage-subsidies and grants to assist businesses to restructure their work place or to purchase special equipment.

However, many disabled persons simply cannot take a job. For these, there must be income security programs to ensure that they have the money required to live decently and in dignity.

Looking at the level of benefits offered by existing income security programs for the disabled, it is clear to me governments can and should do better. I am not pointing a finger only at other levels of government because one of the offenders is a program which I administer. I am referring of course, to the disability provisions of the Canada Pension Plan.

Currently, about 88 000 Canadians receive Canada Pension Plan disability benefits. The maximum amount paid by these pensions is \$268.64 a month. This is made up of a flat-rate portion of \$62.91 paid to all recipients, plus a portion related to previous earnings which can be up to \$205.73. Because of this earnings-related feature, most disabled beneficiaries do not get the maximum, and the average CPP disability benefit is only about \$205.00 a month. Even the maximum of \$268.00 a month is not enough to live on...not at today's prices.

In my view, one could argue that there should be a similar level of benefits available under government programs to the severely disabled, who cannot be expected to participate very much in the work place, and to the retired. Certainly, I hope to be in a position to discuss with provincial Ministers proposals to substantially improve disability benefits under the Canada Pension Plan. A review of the benefits is on the agenda of the next meeting of federal provincial social services ministers.

Undoubtedly many of you are wondering "what about all the other disabled Canadians, those who do not qualify for benefits from the CPP?" Most must rely on a variety of provincial programs such as social assistance and workers' compensation. To provide them greater income security will require close cooperation between the federal and provincial governments. I am very optimistic this will happen. Last December, when I met with the provincial and territorial ministers of social services each one expressed his or her strong commitment to bettering programs for

the disabled. These were sincere expressions of intention to act, not lip service.

One of the most interesting recommendations made by the Special Committee on the Disabled and the Handicapped was for a comprehensive Disability Insurance Program. I hope federal and provincial governments will study together the feasibility of such a program as a long-term solution to providing income security for the disabled.

Income, of course, is not the only problem facing the disabled. I would like to talk about some of the other concrete "non-income" measures of special interest to blind and vision-impaired persons. More specifically, I want to tell you how the federal government is responding to recommendations of the Special Committee on the Disabled.

To judge by their plans various government agencies soon will be providing more audio material for blind and vision-impaired people which was one of the recommendations of the Special Committee's report, Obstacles. I am very proud of my department's initiative to make information on family allowances and old age benefits available in braille and large-type editions and on cassette records.

The National Library of Canada is trying to coordinate reading services across Canada and an interdepartmental committee on copyrights is clearing up legal tangles. The CRTC is urging cable operators to produce more programming for the disabled. The CBC, for its part, believes reading services are best at the local community level, and it is offering technical advice, and where needed, its facilities to deliver the signal to a cable head. The readings could be available on local FM channels or cable facilities.

The House Special Committee has asked that disabled persons be given access to federal publications and all federal



departments be required to utilize up to 1% of their total publicity and information budgets to produce publications and public documents in braille, large-type and cassette.

Another goal is to produce paper money in denominations identifiable by visually-impaired and blind people, which is another recommendation of the Special Committee. The Bank of Canada has been studying a variety of approaches and hopefully, it will find a solution before the end of the International Year of Disabled Persons.

I would like to mention the Special Committee's recommendation pertaining to treatment and research centres for certain disabilities, such as deaf-blindness which will necessitate cooperation between governments and voluntary groups to help fund special treatment centres, and to help train the health professionals so badly needed in this area.

We all agree that existing services for deaf-blind people are inadequate. Your managing Director Mr. Mercer pointed out, "the situation of most deaf-blind youths and adults (in Canada) can only be described as desperate and neglectful".

In its brief to the Special Committee, The Canadian Deaf-Blind and Rubella Association, recommended setting up a federally-funded general registry system for deaf-blind people; amendments to allow income tax deductions to pay for "intervenor" for deaf-blind persons; summer and year-round recreational programs for children; extension of education beyond the age of 18; pre-school programs; more trained personnel; more care to prevent harmful, early labelling of children; home-visits by teachers; job-training and placement, again for the deaf-blind; funding for hearing aids; access to properly trained specialist-teachers and trained people to fill in during family emergencies.

These recommendations involve a number of different jurisdictions and deserve very careful study. At the heart of many of



the recommendations is the concept of "intervention", which has a special meaning for deaf-blind persons. To cite a very famous example, an "intervenor" plays a role similar to the one Annie Sullivan played for Helen Keller.

The study by Joan Mactavish of the CNIB's Ontario Branch offers fascinating and useful information on this question. It recommends that a national sophisticated centre for Deaf-Blind services be created. Valuable ideas also emerged from your conference on deaf-blindness. Here, too, attention was focussed on creating a centre in Canada based on the model of the Helen Keller National Center for Deaf-Blind Youths and Adults. Since its establishment in 1969 by an Act of the U.S. Congress, this institution has been a great service to deaf-blind people.

Another conference recommendation proposed a national study to decide how best to serve the needs of the deaf-blind population. Officials of my Department have been alerted to this proposal, and I urge you to contact them. As well, I suggest you enlist the support of the Medical Research Council.

In conclusion, I want to commend the business community for the efforts it is making to hire the disabled. To cite two examples, the Toronto Dominion Bank has set up a nationwide program to hire the handicapped and Simpson's has used disabled models in its catalogue.

A recent Canadian Chamber of Commerce study shows that employers find disabled persons perform at least as well, and in some cases, better than regular employees in several key areas. These include: job performance, safety record, attendance and length of stay. I am sure that the conclusions of this study will encourage many other employers to hire the disabled.

The great wave of public support for disabled veterans after the Second World War has had a lasting effect on Canadians. Rehabilitation methods and technology developed at that time have

led the way to further advances, and a model of enduring value was set for integrating disabled people into the mainstream of Canadian life. I believe that something similar is happening now during the International Year of Disabled persons. What will make it work is the dedication of people like you in the CNIB.

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Office of the Minister  
The Honourable Jake Epp

Cabinet du ministre  
l'honorable Jake Epp

AN ADDRESS BY THE HONOURABLE JAKE EPP,  
MINISTER OF NATIONAL HEALTH AND WELFARE

TO

THE GENERAL COUNCIL  
THE CANADIAN MEDICAL ASSOCIATION  
ANNUAL MEETING

AUGUST 25, 1987  
CHARLOTTETOWN, PRINCE EDWARD ISLAND  
2:00 P.M.

CHECK AGAINST DELIVERY



Health  
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Canada



Thank you Dr. Dyck, Mr. Chairman, ladies and gentlemen.

It is a great pleasure to be speaking to you again, here, in Charlottetown the constituency of my Cabinet colleague, The Honourable Tom McMillan.

Because you are more than health professionals, because you are involved citizens and participants in social issues that go well beyond the boundaries of health care, I want to speak to you today as Chairman of the Cabinet Committee on Social Development on what this government's approach to social policy has been and how we have implemented that approach during the first three years of our mandate.

Too often, debates on the role of government in social policy assume an either/or choice of two extremes. Either government must adopt a "hands off" approach and leave the resolution of social issues to forces and trends at work within society, or it must address those issues exclusively by government action.

This government, and, I believe, most Canadians, know that appropriate social policy demands something more than simply choosing between these two approaches. There are issues where strong government intervention is the appropriate strategy. There are others where that kind of intervention adds to the problem instead of contributing to the solution - just as doctors know that while some health problems must be addressed by surgery, others respond best to rest and the body's natural healing processes.

The real issue is not which approach is best, but what approach is best in the particular circumstances that confront us. And, both in medicine and in politics, there are few hard and fast rules.





There are, however, principles based on experience which can guide us. I want to discuss some of the principles which have guided this government in its approach to social issues and give some examples of our actions and accomplishments.

## I. IMPROVING THE PUBLIC ENVIRONMENT

First, we believe that just as people are healthier when they have clean air to breathe, unpolluted water to drink, and a safe workplace at which to earn their living, people are also better able to escape from poverty and find secure and rewarding jobs when government pursues the sound fiscal and monetary policies which provide a healthy economic environment.

Let me illustrate that point.

When we came into office in 1984, we inherited a situation in which two years into an economic recovery, the number of Canadians living in poverty was still going up, as was the incidence of poverty among Canadian children. Average real incomes were still falling, and the poorest Canadians were getting a smaller share of this shrinking pie than when the recession ended. We were also confronted with an unemployment rate in 1984 higher than that of the recession year 1982, and by a federal deficit which, on a national accounts basis, had ballooned by over \$10 billion between 1982 and 1984.

The conventional wisdom at the time was that we could either ignore the deficit and try to stimulate the economy to attack poverty and unemployment, or focus on reducing the deficit at the cost of increasing poverty and unemployment.



Instead, we adopted a strategy to simultaneously address all three priorities. Having concluded that any positive effects of federal spending were being more than offset by crippling interest rates and misguided interventionist initiatives such as the National Energy Program, we proposed to gradually reduce the deficit, undo some of the damaging policies of our predecessors such as the NEP, target assistance better to those least able to help themselves, and thus help create an environment where interest rates could come down and the attack on unemployment and poverty could be better focussed.

The opposition parties responded that our policy was really one of deficit reduction at the expense of the poor and the unemployed. They forecast that it would cost tens, if not hundreds, of thousands of jobs, that more and more Canadian families would fall into poverty and that general living standards would drop. They also argued that if any benefits did flow from these policies, they would be monopolized by the already prosperous regions of the country.

Today, almost three years into our mandate, those gloomy forecasts can be checked against hard evidence.

And what does that evidence reveal?

It reveals that between 1984 and 1985, the last year for which data is available, the number of Canadians below the National Council of Welfare's poverty lines dropped for the first time since 1980 as 263,000 people, including 96,000 dependent children, climbed over the poverty wall. What is more the proportion of Canadian families living in poverty fell in every single province between 1984 and 1985 and the decline was steeper in the Atlantic Provinces than it was in any other region of the country.



It reveals that as of July of this year, the seasonally adjusted unemployment rate in every province was at least one percentage point lower than in September 1984. It reveals that the number of Canadians with full-time jobs increased by 513,000 between 1984 and 1986 compared to an increase of 201,000 between 1982 and 1984 and that, outside Ontario, the net gain in full-time jobs rose from 76,000 in the 1982-84 period to 237,000 between 1984 and 1986.

It reveals that for the first time since 1980, average real family incomes, both before and after deducting personal income taxes, went up between 1984 and 1985, again the last year for which data is available. And those gains were not negligible. On an after-tax basis they amounted to \$424 per family in 1985 dollars. Moreover, in 1985, the poorest fifth of both families and unattached individuals recorded all-time high shares of total after-tax income for their groups.

All this is compelling evidence that, by helping to put in place and maintain a healthier economic environment, the government laid the groundwork for social progress in the form of reduced levels of poverty and unemployment and a more progressive distribution of after-tax income.

The importance we attach to a sound policy environment is also illustrated by our approach to such issues as tax reform and our legislation on drug patents.

The tax reform proposals introduced on June 18th by my colleague, The Honourable Michael Wilson, extend the prospect of greater fairness and better incentives to all Canadians. They will remove 850,000 low-income persons from the tax rolls entirely, increase the share of total taxes paid by corporations,





reduce tax rates on the next dollar of income earned by most taxpayers and make the tax system as a whole more progressive by converting most standard exemptions and deductions, which provided disproportionate benefits to upper-income taxpayers, to tax credits which are of the same value to all taxpayers.

The new drug-patent legislation of my colleague, The Honourable Harvie Andre, currently under consideration is also designed to establish a sound policy framework within which Canadians can achieve important social goals.

The legislation he is reforming allows the developers of new prescription drugs effectively only four years of patent protection. After that time rival manufacturers are able to copy and sell the drug upon payment of a nominal royalty of 4% to the company holding the patent.

What happens, of course, is that only commercially popular drugs are copied, prices of non-copied drugs are higher than they otherwise would be because of incurred development costs of copied drugs, research and the introduction of new drugs in Canada is discouraged and our researchers and universities are shut out of opportunities for employment in state-of-the-art work in this field.

The justification for this policy has been that it meant cheaper drugs for Canadian consumers and for governments sponsoring drug plans for the poor and the elderly. That argument, of course, ignores the fact that only the prices of copied drugs are held down and that these represent only one-fifth of the total prescription drug market. The current policy does not control in any way the prices of non-copied drugs.



Our policy does not rely on the expropriation of intellectual property to achieve its ends. That policy consists of extending the term of patent protection to ten years for newly discovered drugs, a price review board for all prescription drugs with the power to roll back price increases over the general rate of inflation, and contingency funding for additional costs which may be incurred by provincial drug plans as a result of the new policy. Drugs now being copied and several now in the pipeline would continue to be available from generic manufacturers, and reputable analysts have calculated that the overall cost of prescription drugs may well be less under the proposed policy than they would be under the current one.

Moreover, major drug manufacturers have publicly stated they would respond to such a policy by new investments of several hundred millions of dollars, providing job opportunities in the thousands for Canadian researchers and scientists.

The unelected majority in the Senate, however, has decided that it can score political points by pandering to fears that the new policy has been solely in response to pressure from American-owned drug firms and the U.S. government. That argument not only ignores the representations which have been made by western European drug manufacturers and their governments, it assumes that a policy which is manifestly in Canada's public interest should be rejected simply because it also is supported by the U.S. government. That strikes me as a singularly unintelligent way to make public policy.

## II. DIRECT ACTION ON INCOME SECURITY

A second principle which has guided us is that government has a responsibility to provide a basic measure of



income security to those who, for reasons of age, disability, or other circumstances are unable to provide for themselves and their families.

Allied to that responsibility is the provision of social insurance against such risks as unemployment, old age, ill health, disability and the death of an income-earning spouse to ensure that, while people are healthy and earning incomes, they can provide for those contingencies which remain all too commonly a part of our lives. People also require the assurance that our social insurance programs are soundly financed and that supplementary protection, whether obtained through employers or by individuals directly, is subject to appropriate regulation.

In three short years we have also taken substantial action to implement this principle.

Eligibility for the income-tested Spouse's Allowance program has been extended to all widows and widowers between age 60 and 65. Previously, only those persons whose spouses had died after reaching age 65 had qualified for this program. Targetting has also been improved in the child benefits system by enriching the refundable child tax credit while reducing tax deductions which disproportionately benefitted upper-income families with children.

Long-discussed reforms to the Canada Pension Plan, to the tax treatment of contributions to Registered Retirement Savings Plans and to the regulation of employer-sponsored pension plans including better vesting and portability provisions, expanded contribution limits, improvements to disability and survivors' benefits and better provisions for credit-splitting between spouses on marriage breakdown are now law as a result of







action by this government. Moreover, the financing of the Canada Pension Plan has been reformed to put it on a sound basis for the next twenty-five years.

Canada's veterans have also witnessed a series of administrative and legislative improvements to their income support programs.

Charlottetown, of course, is the home of the federal Department of Veterans' Affairs, a department that has new zest, thanks to the remarkable work of my Cabinet colleague, The Honourable George Hees. Today, Veterans' Affairs is a major factor in this city, providing jobs for more than a thousand people - only 10% of whom were transferred here from elsewhere in Canada - and managing a payroll of more than \$30 million annually.

But even more important than the money, is what the money is being used for. Quite simply, it is providing justice for Canada's veterans - justice that was, in too many cases, long overdue. In the past three years, the number of veterans' pension applications has increased by one hundred per cent as more of our veterans get closer to the age of 65. Despite the increase, however, the time needed to process applications has fallen by an astounding 65 per cent.

### III. A SENSE OF LIMITS

As a third principle this government also believes that good social policy recognizes a sense of limits. Over two hundred years ago, Edmund Burke described government as "a contrivance of human wisdom to provide for human wants". By "wants" Burke did not mean government should be there to provide everything people desired. Its purpose, as Abraham Lincoln



restated it a century later, was to do only those things which were needed for a good society but which people either could not do at all for themselves as individuals or could not do so well as individuals as they could do collectively through government.

There will always be legitimate debate as to precisely what things can best be done by government, but the point I want to emphasize is that government cannot do everything. If it tries, it will sooner or later be unable to do even what most citizens would agree is truly essential.

That is why I as a social policy minister have fully supported the commitment of this government to bring the federal deficit under control.

We strive to practice self-restraint not just in the spending of tax dollars. Whether we are launching education and research programs on AIDS, proposing a ban on the advertising of tobacco products, or reforming the criminal law to deal more effectively with pornography or child abuse, we intervene only once we have been persuaded that there is a clear need to do so and that the intervention is no more than what is required in the circumstances.

Let me expand on the initiatives I have just mentioned.

First, AIDS.

In speaking with you today, I am aware of how much more we know now about the threat of AIDS than we knew even a year ago. We recognize that, of all the challenges faced by the medical profession today - faced by society today - AIDS is one of the most urgent and challenging. There is already a significant impact on health and the health care system as a



whole resulting from AIDS. I appreciate the valuable work you are doing at the front lines and in partnership with other professionals and the voluntary sector.

The federal government's \$39 million for AIDS, announced in 1986 as part of a five year plan, is assisting as well.

In order to strengthen its concerted attack on AIDS, the Department of National Health and Welfare has expanded its AIDS Centre and consolidated various functions previously carried out in several of the Department's branches into the Federal Centre for AIDS (FCA). Working within the Health Protection Branch, the Centre which will be fully operational within weeks, will carry out laboratory and research work, epidemiology and surveillance, coordination of clinical trials for drugs and vaccines, and a host of other activities.

I'm sure you are aware of the exciting news that an AIDS vaccine has been approved for clinical trials in the United States.

This vaccine results from cooperation on an international scale involving the manufacturer, the U.S. National Institutes of Health, The National Institute for Medical Research in London, England, and the Laboratory Centre for Disease Control in my department.

L.C.D.C., with access to a primate colony, tested the potential vaccine for immune response and determined there were no adverse effects on the health of test animals.

Work continues on other vaccines for the AIDS virus with government - private sector cooperation.





Also part of the federal government initiative on AIDS was a virus culture laboratory in British Columbia. This Lab, jointly opened by the federal government and the government of British Columbia, will enable more clinical trials of AIDS drugs to be carried out in Canada.

In addition, we will search for better ways to get the message about AIDS across to the public. We will be seeking the advice of the provinces and relevant associations such as yours.

As you know, we have also been active in discouraging the consumption of tobacco. It is important for people to understand why smoking, which was once a personal habit, has become a legitimate public policy concern. Second-hand smoke, whether it is absorbed by the unborn child in the womb or inhaled by the worker at the next desk, we now know endangers non-smokers as well as smokers. Furthermore, smoking adds substantially to the burden on an already hard-pressed medical profession and on health resources.

In 1985 my provincial counterparts, several national non-government organizations, my department and I joined forces to encourage Canadians, especially young people, to create a generation of non-smokers.

In April of this year, with support from the President of the Treasury Board, the Honourable Robert De Cotret and the Minister of Labour, the Honourable Pierre Cadieux, on behalf of the government, I announced our intention to introduce legislation banning tobacco advertising and promotion in Canada. We also strengthened the existing commitment to the National Program to Reduce Tobacco Use. We introduced Bill C-51, The Tobacco Products Control Act, in the House of Commons April 30, 1987.



However, despite the fact this initiative has begun, there is still much to be done before we are able to prevent the thousands of smoking-related illnesses and deaths in Canada each year. We need your continued help. Indeed more than ever before.

Groups such as the C.M.A. and the Physicians for a Smoke- Free Canada have been enormously helpful. Individually and collectively we can win this one, despite strong lobbying on the side of those whose self-interest lies in having people continue to smoke.

Tobacco manufacturers have deliberately sought to make alliances with the sports and cultural communities in Canada through sponsorships and promotions. They are now calling in those past favours and we are seeing the results in slick letter-writing campaigns and full-page newspaper ads.

We understand that the ban on the use of cigarette brand names in sports and cultural promotion will cause disruption to those who have come to depend on this source of revenue but only because tobacco companies have refused to continue such promotion under their corporate names as the legislation allows. I think that very clearly shows that their motivation all along has not been to be good corporate citizens, but to use sports and culture as a vehicle to hook Canadians on their products.

I note that there have been objections to the advertising ban on tobacco on the grounds that it curtails free speech. I reject that argument for several reasons. First, free speech is never an absolute; you are not free, for example, to falsely shout "Fire" in a crowded theatre. In such an event, the result would be more harmful than limiting freedom of speech.



The situation with respect to tobacco advertising is precisely the same: the damage it creates is more of a threat to society than the limit proposed.

Moreover, we can be excused for rejecting the argument that advertising does not increase tobacco use. It is only reasonable, in fact, to assume that advertising does have an impact on people's behaviour. Surely, if it did not, companies would not spend millions of dollars using ads to persuade us to buy their goods and services.

By cutting out ads, we are also sending a clear signal that smoking is not a socially acceptable behaviour. Finally, we are clearing the way for one unambiguous message: smoking is dangerous to individual health and to the health of others.

As we battle the diseases that threaten the human body, we must remain aware of those that threaten the human spirit. One of the most insidious today is pornography. I am well aware that attempts to control pornography, like attempts to control smoking, are rejected by some people as being unwarranted limits to freedom.

I accept that their beliefs are strongly held but they are, nonetheless, misguided. I cannot accept the argument that the right to free speech includes the right to produce pornography that panders to the need to degrade and brutalize people, women and children in particular.

Nor does pornography exist in a vacuum. That is why the federal government has taken strong steps to respond to the Badgley Committee Report, which dealt with child sexual abuse in Canada. For too long, people had assumed that the problem was isolated and the result of a rare, easily detected aberration.







We now know that such abuse is only too common and that it exists at every level of society. I daresay that, as doctors, many of you here today have discovered that every community - no matter how vigilant its citizens - is vulnerable to sexual abuse of the young.

Now, changes to the Criminal Code and the Canada Evidence Act provide severe penalties for those sexually exploiting persons under 18. They increase the penalty for those who live off the avails of juvenile prostitution. In order to make those amendments enforceable, children may be unsworn witnesses in sex abuse cases, without corroboration, and videotaped statements, describing sexual abuse, will be permitted.

#### INVESTING IN PEOPLE

I mentioned earlier that one of our guiding principles was a sense of limits both in fiscal and policy terms. But within those limits, much can be and is being done to invest wisely in people and through them in Canada's future.

In fact, the two are directly related. Only by being prudent with tax dollars and not over-reaching what we can do effectively in policy terms are we able to free up resources to tackle new social challenges and to address old ones in new ways.

By the end of this year the federal government will be announcing a significant additional commitment to child care in Canada. That additional commitment, like any investment, and particularly one involving our children, will be made with care.

That is why a Parliamentary Committee and an extensive federal-provincial consultation have preceded decision-making and an announcement by the federal government.



We recognize that circumstances have changed significantly for Canadian families with young children over the past twenty years. The two-earner couple has become the norm rather than the exception and, although many families are able and, in fact, choose to rely on close relatives and trusted neighbours for their child care needs, many others simply do not have that option. While we believe that the primary financial responsibility for the care of children should remain with their parents, the policies we plan to announce will be designed to address the child care needs facing parents in a wide variety of circumstances. Those needs vary and no single solution can address them either fairly or comprehensively.

The consultative approach we are applying to child care has also improved the quality of our investment in helping Canadians escape from dependence on social assistance, by providing them with skills and job opportunities through the Canadian Jobs Strategy and by allowing them to keep more social assistance benefits while they are making that difficult transition.

Linking social assistance and the Canadian Jobs Strategy involved intensive consultation between federal and provincial welfare and employment ministers and individual bilateral arrangements with each province.

In developing the six new programs under the Canadian Jobs Strategy, the Honourable Flora MacDonald who was then Minister of Employment and Immigration started from the ground up by reaching out to individuals and groups across Canada, asking them to offer innovative ideas for dealing with labour market issues.



The essential importance of the Canadian Jobs Strategy is that, first, it recognizes that not all good ideas lie within government. Second, it is an investment in people, helping them define what they want, and then helping them make changes in their lives.

#### IV. PRIVATE TROUBLES-PUBLIC CONCERNS

Fourth, just as we believe that preventive health measures go hand-in-hand with the treatment of injury and illness, many social problems involving the welfare of children and strains on family life can be more effectively prevented and treated by enabling people to deal with their private troubles before they become public concerns and assisting them to put the pieces back together again when a crisis occurs.

Amendments to divorce legislation and more effective laws to enforce court maintenance orders have met better protection to parents given custody on marriage breakdown and to their children.

To respond to another important family concern, the then Solicitor General, The Honourable Perrin Beatty launched important new efforts to help parents and volunteer groups find missing children and return them safely to their homes.

Finally, as most of you will be aware, the government of Canada committed in May of this year \$210 million to a 5-year comprehensive action plan to curb drug abuse.

Because action begins with awareness, one of the first priorities was to communicate with Canadians about the changing patterns of drug abuse and supply.







The initiative began with a Health and Welfare announcement which, because drug abuse cuts across all segments of society, was followed by announcements by five other Ministers - the Solicitor General, the Minister of State for Youth, the Minister of National Revenue, the Secretary of State for External Affairs and the Minister of Justice.

This initiative, in which we closely co-operated with provincial and local experts in the field, was complemented by T.V. ads unveiled in June designed to reach young people before they begin experimenting with alcohol and drugs. You may have seen some of those spots based on the theme, "Really Me".

The strategy addresses the issue comprehensively, involving legislation, treatment, prevention and enforcement. It also involves an international dimension. This spring, the government of Canada signed the United Nations convention on psychotropic drugs, a vital step in combatting drug abuse which our predecessors had procrastinated for over a decade after Canada played a major role in drafting the convention in the early 1970s.

The National Drug Strategy first came to public attention when the Prime Minister made strong reference to it in a speech last year. Work had, however, been proceeding for several months prior to that as the issue was on our agenda and has since been addressed with concerted action and leadership because the Prime Minister identified as a parent as well as the leader of government, with the family tragedies and lost human potential that drug and alcohol abuse create in our society.

Let me for a moment be personal and tell you that this instance in respect to the drug strategy is representative of the



leadership which the Prime Minister has made in so many areas affecting not only my portfolio and social policy, but indeed, the entire government agenda.

Today we have reviewed social policy and how the government has moved in areas affecting these basic needs and rights of individual Canadians. Additionally, I think it is clear that this government sees the necessity of a compatibility between social policy and a strong economic base. Without a healthy economy, there is no room for improved social policy. Further I have outlined some of the initiatives of my cabinet colleagues but I think it is important that for a moment I indicate to you the dynamic which makes this all possible.

The Right Honourable Brian Mulroney has brought together the various elements of the Canadian mosaic - something which has not always been the case in our history. Additionally, building on that base and with the support of Canadians as given in the 1984 election, he has shown leadership and conciliation with the Provinces and Premiers - creating a new era of federal provincial relations. National dialogue has become a reality and it is this atmosphere which has allowed us to move forward in so many of the areas discussed today.

#### V. QUALITY OF LIFE - FAIR OPPORTUNITIES FOR ALL

And that brings me to the fifth and final principle which has guided the social policy of this government. That principle is the belief that, by preserving for our citizens the richness of Canada's natural and cultural heritage and by opening as widely as possible the doors of economic opportunity, we not only preserve and enhance their chances for a good quality of life, we also enable them to make a fuller contribution to their families, to their communities, to Canada and to its future.



That principle has many applications and I can only draw some of them out very briefly today. They range from enhancing the dignity of our native peoples by working to turn over to them greater responsibilities for their own self-government to creating the conditions under which our writers, musicians, artists, sculptors, broadcasters and filmmakers will be stimulated to enrich our cultural heritage. They include this government's decision to enlarge opportunities for qualified women by doubling their representation in positions appointed by the federal cabinet and, more broadly, through Canada's first employment equity legislation to increase employment opportunities not only for women but also for visible minorities and the handicapped and disabled.

This government has also moved to strengthen and reinforce the rich multi-cultural heritage we are gradually building in Canada and to fulfil our international responsibilities as a haven for legitimate refugees. In the current clamour over the legislation now before the House of Commons to deter those who would abuse the refugee system, it is easy to overlook the fact that last year the number of immigrants allowed into Canada was at its highest level since 1982 and that 1986 marked the first year in which immigration increased since 1980.

So far in 1987, immigration is well ahead of the pace set in 1986 and the intake of refugees has increased along with immigration as a whole.

As the son of an immigrant who came to this country after being on the losing side of the Russian Revolution and Civil War, I have long been an advocate of more open immigration policies, and it is from that perspective that I support the







legislation now before Parliament. For, unless we can convince Canadians that abuse of our refugee and immigration procedures will not be tolerated, the well of public support for the admission of legitimate immigrants and refugees will first be poisoned and then evaporate.

Along with enlightened policies to enrich Canada's human and cultural resources, another essential foundation of a good quality of life is people's ability to live and work in a safe and healthy environment. In that respect, I pay tribute to Tom McMillan for his work as Minister of the Environment.

Amongst the government's pioneering legislation is the new standard for lead emissions in vehicles; an amended National Parks Act that, for the first time, gets tough with those who slaughter protected wildlife for personal gain; and the new Environmental Protection Act that deals with chemicals through their life cycle - from manufacture, to distribution and use, to disposal. In every case, people's lives have been improved because the Canadian environment is being made healthier and safer for us and for our children.

In speaking of the new Environmental Protection Act, I should also mention another government initiative that those of you interested in workplace health will find of particular interest - the Workplace Hazardous Materials Information System, or WHMIS, as it is called.

WHMIS, which, federally, falls under the Department of Labour, is pan-Canadian legislation; in concert with similar provincial statutes, it establishes the right of Canadians to be told if they are working with hazardous materials, what is in those materials, and how they must be used.



Like many of the government's programs, it is the result of ongoing consultation with all interested parties: in this case, industry, labour, and the federal and provincial governments. When the Mulroney government took office, almost three years ago, it promised a new era of consultation. I can tell you that many of the initiatives I've been describing today owe their success to the kind of co-operation with other governments, with the private sector and with individual Canadians that has never been seen before in Ottawa.

And Canadians, both individually and through the associations to which they belong, have responded with a host of thoughtful oral and written presentations. I want to pay particular tribute today to the Canadian Medical Association for the report you issued this year entitled Health Care for the Elderly - Today's Challenges, Tomorrow's Options and for the good advice and encouragement I know will be forthcoming as we consult with you on our health promotion paper and other aspects of the health care system.

In attempting today to explain why we have taken the actions we have on social policy issues as well as list some of what we have accomplished, I have, of course, been concerned with improving your perception of that record. Because it has happened gradually, because it has often been overshadowed by more dramatic side issues, and because we still have a long way to go, it has been a record all too easy to ignore or to misunderstand.

But it is a record and an agenda for the future which I take pride in. And I would close by reminding you that a record like this doesn't just happen. It has taken leadership from our Prime Minister, the hard work of my colleagues in cabinet and



their departmental staff, co-operation from provincial governments and the advice and support of individual Canadians and groups such as the C.M.A.

With your continued help and support I know we can build on that record in the future. Thank you for your patience and attention.





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canada**

Office of the Minister  
The Honourable Jake Epp

Cabinet du ministre  
l'honorable Jake Epp

3RD WILDER PENFIELD LECTURE

GIVEN BY

THE HONOURABLE JAKE EPP

MINISTER OF NATIONAL HEALTH AND WELFARE



MONTREAL NEUROLOGICAL INSTITUTE

MONTREAL, QUEBEC

FRIDAY, SEPTEMBER 18, 1987

CHECK AGAINST DELIVERY



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## SCIENCE, HEALTH AND PUBLIC POLICY

### INTRODUCTION

WHEN I RECEIVED DR. BAXTER'S INVITATION TO PARTICIPATE IN THIS PRESTIGIOUS FORUM, I ACCEPTED WITH A GREAT SENSE OF PRIDE. IT IS AN HONOUR TO BE HERE AND TO FOLLOW SUCH DISTINGUISHED WILDER PENFIELD LECTURERS AS DR. JULIUS AXELROD AND DR. WILLIAM GIBSON.

HAVING ACCEPTED TO GIVE THE 3RD WILDER PENFIELD LECTURE, I STARTED TO WONDER WHY A SCHOOL TEACHER TURNED POLITICIAN HAD BEEN SELECTED TO SPEAK. HOWEVER, AS I LOOKED FURTHER INTO THE LIFE AND CAREER OF WILDER PENFIELD, I BEGAN TO UNDERSTAND THAT HIS VIEW OF OUR WORLD SOUGHT TO BRING TOGETHER THE CREATIVE ENERGIES OF US ALL - SCIENTIST AND LAYMAN ALIKE.

DR. PENFIELD'S LIFE WAS DEVOTED TO ALLEVIATING THE SUFFERING ASSOCIATED WITH NEUROLOGICAL ILLNESS, AND TO ATTEMPTING TO UNDERSTAND THE FUNCTION OF THE HUMAN BRAIN IN HEALTH AND DISEASE. HE FIRMLY BELIEVED THAT THE STUDY OF THE HUMAN NERVOUS SYSTEM WAS THE KEY TO UNDERSTANDING MAN HIMSELF. THUS HE SAW HIS WORK IN THE CONTEXT OF CURRENT PROBLEMS OF SOCIETY; HE WAS INTENSELY INTERESTED IN THE PROMOTION OF HEALTH AND OF BIOMEDICAL RESEARCH, AND HE WAS VERY MUCH AWARE OF THE ROLE THE ARTS PLAY IN THE DEVELOPMENT OF A NATION.



THROUGHOUT HIS CAREER, DR. PENFIELD STROVE TO BUILD BRIDGES -- BRIDGES THAT ARE NEEDED TODAY BETWEEN THINKERS, BETWEEN DISCIPLINES AND BETWEEN CULTURES. WHILE HE MOVED IN THE SCIENTIFIC WORLD, HE POSSESSED A STRONGLY CLASSICAL BACKGROUND AND ENJOYED A KEEN INVOLVEMENT IN SOCIAL AND ETHICAL ISSUES. HE SOUGHT TO AVOID THE GROWING GAPS BETWEEN NEUROLOGY AND NEUROSURGERY, BY INSISTING THAT THE TWO BE COMBINED IN THIS INSTITUTE. HE ENCOURAGED FRENCH AND ENGLISH PHYSICIANS TO SHARE THEIR STRENGTHS. CLEARLY, DR. PENFIELD REGARDED THE HUMAN ENDEAVOUR NOT AS A SERIES OF ISLANDS SEPARATED BY FREQUENTLY DANGEROUS WATERS, BUT AS A CHAIN OF LAND FORMS -- A CONTINUUM OF OVERLAPPING AREAS OF KNOWLEDGE AND ABILITIES.

DR. PENFIELD APPLIED THIS SAME KIND OF THINKING TO SOCIAL POLICY, AS IS CLEARLY INDICATED BY HIS WORK WITH THE VANIER INSTITUTE OF THE FAMILY, INCLUDING HIS SERVICE AS THE FIRST PRESIDENT OF THAT ORGANIZATION.

IN THE 1930'S DR. PENFIELD SAW FUNDAMENTAL AND APPLIED STUDIES OF THE BRAIN AS THE KEY TO UNDERSTANDING OURSELVES. AN ESSENTIAL STEP WAS THE CREATION OF THIS INSTITUTE, THE MNI, WHICH HE DEDICATED "TO THE RELIEF OF SICKNESS AND PAIN AND TO THE STUDY OF NEUROLOGY". IN THE 1960'S, AS HIS BIOGRAPHER JEFFERSON LEWIS IMPLIES, DR. PENFIELD THREW HIMSELF WHOLEHEARTEDLY INTO THE WORK OF THE VANIER INSTITUTE BECAUSE HE SAW THE FAMILY AS THE CENTRAL





SOCIAL STRUCTURE WITHIN WHICH THE SCIENCE DEVELOPED AT RESEARCH INSTITUTES SUCH AS THE MNI COULD BE APPLIED, NOT JUST TO TREAT THE INDIVIDUAL PATIENT, BUT ALSO THE FAMILY AND HENCE SOCIETY AS A WHOLE.

I HAVE PROFOUND RESPECT FOR HIS EFFORTS. THEY WERE GUIDED, I BELIEVE, BY AN UNDERSTANDING THAT SCIENCE, HEALTH AND PUBLIC POLICY ARE INEXTRICABLY LINKED. I SHARE THAT VIEW AND DR. PENFIELD'S SINCERE DESIRE TO IMPROVE THE HEALTH OF ALL CANADIANS.

TONIGHT, I'D LIKE TO EXAMINE THE TRIANGLE THAT THESE WORDS FORM - - TO DEFINE THEM AS I SEE THEM, TO EXPLORE THEIR LINKS AND THE CHALLENGE OF INTEGRATING THE THREE CORNERS INTO A WHOLE.

### THE TRIANGLE

LET ME BEGIN WITH HEALTH, AS IT HAS COME TO BE UNDERSTOOD IN CANADA AND OTHER COUNTRIES WORKING IN COLLABORATION WITH THE WORLD HEALTH ORGANIZATION. OUR PERSPECTIVE ON HEALTH HAS DEVELOPED FROM A SOMEWHAT LIMITING VIEW EQUATING HEALTH WITH THE ABSENCE OF DISEASE, TO A MORE POSITIVE OUTLOOK THAT EXPRESSES HEALTH IN TERMS OF THE DEGREE TO WHICH PEOPLE CAN REALIZE THEIR ASPIRATIONS, COPE WITH THEIR ENVIRONMENT AND RE-SHAPE THEIR LIVING CONDITIONS TO BETTER SUIT THEIR NEEDS. HEALTH IS NOT AN END IN ITSELF. IT IS A RESOURCE FOR EVERYDAY LIFE, A MEANS TO



MEET THE NEEDS OF THE INDIVIDUAL AND THE INTERESTS OF THE COMMUNITY.

THIS DEFINITION HAS IMPORTANT IMPLICATIONS FOR SCIENCE AND FOR PUBLIC POLICY. THE FOCUS SHIFTS - FROM MORTALITY AND MORBIDITY STATISTICS TO THE RELATIONSHIP BETWEEN MIND, BODY AND SPIRIT; FROM INTERVENTION AND MEDICAL SYSTEMS TO AN ECOLOGICAL APPROACH TO PUBLIC POLICY - A RECOGNITION OF A BASIC TWO WAY EQUATION: PEOPLE SHAPE THE ENVIRONMENT AND THE ENVIRONMENT SHAPES PEOPLE.

THE PURPOSE OF PUBLIC POLICY IS TO STAKE OUT COLLECTIVE GOALS AND THE MEANS BY WHICH THESE GOALS ARE TO BE ACHIEVED. PUBLIC POLICY HELPS TO CREATE THE "LIFESTYLE OF A NATION" BECAUSE THE OPTIONS IT CREATES FOR INSTITUTIONS, GROUPS AND INDIVIDUALS, SET THE BOUNDARIES FOR WHAT CAN AND TYPICALLY WILL BE DONE.

AS THIS JUNCTURE, I'D LIKE TO MAKE TWO ADDITIONAL POINTS ABOUT PUBLIC POLICY, IN TERMS OF ITS SCOPE AND ITS LIMITATIONS.

I BELIEVE THAT THE PROMOTION OF HEALTH DEMANDS THE INVOLVEMENT OF THE FULL SPECTRUM OF PUBLIC POLICY: AGRICULTURE, EDUCATION, FINANCE, EMPLOYMENT, ENVIRONMENT, SOCIAL SERVICES, COMMUNICATIONS AND DEFENCE. JUST AS PEOPLE ARE HEALTHIER WHEN THEY HAVE CLEAN AIR TO BREATHE AND UNPOLLUTED WATER TO DRINK, PEOPLE ARE ALSO BETTER ABLE TO PURSUE EMPLOYMENT, COMFORTABLE



LIVING CONDITIONS AND A POSITIVE QUALITY OF LIFE WHEN GOVERNMENT PURSUES THE SOUND FISCAL AND SOCIAL POLICIES NECESSARY FOR A HEALTHY ENVIRONMENT.

MY SECOND POINT IS SIMPLY THAT GOOD PUBLIC POLICY RECOGNIZES A SENSE OF LIMITS. OVER TWO HUNDRED YEARS AGO, EDMUND BURKE DESCRIBED GOVERNMENT AS "A CONTRIVANCE OF HUMAN WISDOM TO PROVIDE FOR HUMAN WANTS". BY "WANTS" BURKE DID NOT MEAN THAT GOVERNMENT SHOULD PROVIDE EVERYTHING PEOPLE DESIRED. ITS PURPOSE, AS ABRAHAM LINCOLN RESTATED A CENTURY LATER, WAS TO DO ONLY THOSE THINGS WHICH WERE NEEDED FOR A GOOD SOCIETY BUT WHICH PEOPLE EITHER COULD NOT DO AT ALL FOR THEMSELVES AS INDIVIDUALS OR COULD NOT DO SO WELL INDIVIDUALLY AS THEY COULD COLLECTIVELY THROUGH GOVERNMENT.

THERE WILL ALWAYS BE LEGITIMATE DEBATE AS TO PRECISELY WHAT THINGS CAN BEST BE DONE BY GOVERNMENT, BUT THE POINT I WANT TO EMPHASIZE IS THAT GOVERNMENT CANNOT DO EVERYTHING. IF IT TRIES, IT WILL SOONER OR LATER BE UNABLE TO DO EVEN WHAT MOST CITIZENS WOULD AGREE IS TRULY ESSENTIAL.

HOW THEN DOES SCIENCE, THE THIRD CORNER OF THE TRIANGLE FIT IN? SCIENCE (AND I AM TALKING HERE OF ALL ASPECTS OF THE NATURAL AND SOCIAL SCIENCES) PROVIDES THE FOUNDATION FOR ACTION THAT IS BASED ON KNOWLEDGE. AS SUCH, SCIENCE HAS A DUAL ROLE - TO PROVIDE ANSWERS AND RIGOROUS THINKING ABOUT PROBLEMS SOCIETY





IDENTIFIES WHILE AT THE SAME TIME, WORKING TO FIND THE UNEXPECTED, TO RAISE ISSUES AND CONCERNS IN AREAS WHICH ARE NOT YET IN THE PUBLIC AWARENESS. AS A LEADER IN CHANGE SCIENCE IDENTIFIES PUBLIC NEEDS; AS A RESPONDER TO PUBLIC ASPIRATIONS, SCIENCE PROVIDES THE NECESSARY ACCUMULATION OF KNOWLEDGE ABOUT THOSE REALITIES.

LIKE PUBLIC POLICY, SCIENCE ALSO HAS ITS LIMITS. SCIENCE CANNOT ANSWER ALL QUESTIONS; IT CAN ONLY ADDRESS THOSE QUESTIONS FOR WHICH THE AVAILABLE TOOLS ARE APPROPRIATE. THE ALL-OUT WAR ON CANCER WHICH BEGAN IN EARNEST IN THE 1970'S DID NOT CURE CANCER, BECAUSE THE SCIENTIFIC TOOLS WERE NOT AVAILABLE, AND COULD NOT BE DEVELOPED RAPIDLY ENOUGH. HOWEVER, IT DID PUT IN PLACE THE SCIENTIFIC AND TECHNOLOGICAL ABILITIES WHICH, FOR INSTANCE, HAVE CONTRIBUTED ENORMOUSLY TO THE EXPLOSION OF BIOTECHNOLOGY AND TO THE RAPIDITY WITH WHICH THE AIDS VIRUS WERE DISCOVERED.

THERE CAN BE NO DOUBT ABOUT THE DIRECT LINKS BETWEEN THE DEVELOPMENT OF SCIENCE AND THE DRAMATIC CHANGES IN HUMAN HEALTH, PARTICULARLY OVER THE PAST CENTURY. THE RECOGNITION OF THE NATURE OF INFECTIOUS DISEASE WAS THE RESULT OF CAREFUL AND EXTENDED SCIENTIFIC STUDY. FURTHER STUDIES HAVE LED TO METHODS FOR PREVENTING AND TREATING THE MAJOR CAUSES OF PREMATURE DEATH. INDEED, THE DEATH OF SCHOOL CHILDREN DUE TO INFECTIOUS OR OTHER DISEASES WHICH ARE NOW PREVENTABLE OR TREATABLE IS A COMMON



MEMORY OF MANY WHO ARE ALIVE TODAY.

THESE LINKS BETWEEN SCIENCE AND HEALTH ARE REFLECTED IN THE STRUCTURES OF TODAY'S MEDICAL SCHOOLS. THE FLEXNER REPORT OF THE EARLY 1900'S FORMALLY RECOGNIZED THE ESSENTIAL ROLE OF RESEARCH IN MEDICAL EDUCATION, A ROLE WHICH HAD ALREADY BEEN WELL ESTABLISHED HERE AT MCGILL. TODAY THE CENTRES OF RESEARCH AND ADVANCED HEALTH CARE MOST OFTEN ARE FOUND TOGETHER IN THE CENTRE FOR TRAINING AND EDUCATION IN THE HEALTH SCIENCES.

AND SO WE POSSESS A FASCINATING TRIANGLE. HEALTH IS A FUNDAMENTAL RESOURCE FOR COPING OR CHANGING ONE'S ENVIRONMENT. PUBLIC POLICY IS A MEANS TO CREATE ENVIRONMENTS FOR HEALTH AND TO ENACT CHANGE THAT WILL ENABLE PEOPLE TO IMPROVE THEIR HEALTH. SCIENCE IS THE LEADER AND SERVANT OF CHANGE - A MEANS TO IDENTIFY THE NEEDS, THE QUESTIONS AND THE SOLUTIONS IN OUR PURSUIT OF AN IMPROVED QUALITY OF LIFE FOR ALL OUR PEOPLE.

#### ACHIEVING HEALTH FOR ALL

THE NEXT ISSUE IS HOW TO INTEGRATE THEM.

I WOULD LIKE TO DISCUSS THIS INTEGRATION FROM MY PERSPECTIVE AS A MINISTER OF HEALTH, FIRSTLY AS IT RELATES TO SCIENTISTS, AND SECONDLY AS IT RELATES TO POLICY-MAKERS. AND I'D LIKE TO FRAME THAT DISCUSSION BY FOCUSING ON OUR MUTUAL OBJECTIVE - "ACHIEVING



## HEALTH FOR ALL".

LATE LAST YEAR, I RELEASED A DISCUSSION DOCUMENT ENTITLED, "ACHIEVING HEALTH FOR ALL: A FRAMEWORK FOR HEALTH PROMOTION", AT THE FIRST INTERNATIONAL CONFERENCE ON HEALTH PROMOTION, HOSTED BY MY DEPARTMENT, THE WORLD HEALTH ORGANIZATION AND THE CANADIAN PUBLIC HEALTH ASSOCIATION. IT REFERS TO THREE CHALLENGES THAT ARE NOT ADEQUATELY ADDRESSED BY CURRENT HEALTH POLICIES AND PRACTICES, THEN DESCRIBES AND DISCUSSES THE HEALTH PROMOTING MECHANISMS THAT CAN BE USED TO RESPOND TO THESE CHALLENGES, AND THE STRATEGIES FOR THEIR IMPLEMENTATION.

THE FIRST CHALLENGE IS TO REDUCE THE EXISTING INEQUALITIES IN HEALTH STATUS AMONG CANADIANS. STATISTICAL ANALYSIS HAS SHOWN US THE FACTS. MEN WITH GOOD INCOMES IN CANADA CAN EXPECT TO LIVE AS MUCH AS SIX YEARS LONGER THAN THOSE WHO ARE POOR. WOMEN IN A SIMILAR POSITION ENJOY SIXTEEN MORE YEARS OF DISABILITY-FREE LIFE THAN WOMEN IN LOWER-INCOME BRACKETS. RACE, GENDER, AGE, GEOGRAPHIC LOCATIONS AND EMPLOYMENT STATUS ARE OTHER FACTORS THAT CAN POSITIVELY OR NEGATIVELY AFFECT HEALTH STATUS.

THE SUBCULTURES OF DISADVANTAGE RESTRICT PEOPLE'S ABILITY TO SHARE SOME OF THE BASIC KNOWLEDGE THAT SCIENCE HAS GIVEN US. POOR EDUCATION LEADS TO AN INADEQUATE UNDERSTANDING OF THE WORKINGS OF THE BODY AND OF THE WAYS IN WHICH SICKNESS OCCURS, RANGING FROM INADEQUATE KNOWLEDGE OF THE PRINCIPLES OF NUTRITION OR HEALTH PROTECTION TO A LACK OF AWARENESS OF WARNING SIGNS OF





SERIOUS DISEASE SUCH AS THE EARLY SYMPTOMS OF CANCER OR SOME OTHER LIFE-THREATENING ILLNESS.

BROADLY SPEAKING, THE REDUCTION OF INEQUITIES IN HEALTH IS A SOCIAL PROBLEM. YET WHILE THESE INEQUITIES HAVE BEEN WELL-KNOWN FOR DECADES, CLEAR DATA AND A BETTER UNDERSTANDING OF SOCIETAL AND ENVIRONMENTAL INFLUENCES MUST PROVIDE THE BASIS FOR EXERCISING THE DESIRABLE SOCIAL CHANGE. THE MAJOR CONCERN HERE, HOWEVER, IS TO APPLY MORE FULLY AND EQUITABLY THE KNOWLEDGE WE NOW HAVE.

THERE IS LITTLE DOUBT OF THE IMPORTANCE OF SCIENCE IN ADDRESSING OUR SECOND MAJOR CHALLENGE - THE NEED TO INCREASE THE SCOPE OF PREVENTION BY FINDING NEW AND MORE EFFECTIVE WAYS OF PREVENTING INJURIES, DISEASE AND CHRONIC CONDITIONS.

TODAY, MANY PEOPLE TALK OF A "RENAISSANCE" IN MEDICINE AND PUBLIC HEALTH - A RETURN TO THE COMMUNITY-SPIRITED GOLDEN AGE OF PREVENTION WITNESSED IN THE LATE 1800'S AND THE EARLY 1900'S. THE DRAMATIC CHANGES WHICH OCCURRED IN HEALTH IN THOSE TIMES RESULTED FROM THREE IMPORTANT FACTORS. THE SCIENTISTS OF THE DAY TURNED THEIR ENERGY AND CREATIVE THINKING TO INCREASING OUR UNDERSTANDING OF NUTRITION, THE NATURE OF INFECTIOUS DISEASE AND THE DEVELOPMENT OF IMMUNIZATION METHODS. SECONDLY, SCIENTISTS AND PUBLIC HEALTH WORKERS COMMUNICATED THIS KNOWLEDGE TO THE PEOPLE AND THE POLITICIANS, WHILE SERVING AS ADVOCATES FOR



ENVIRONMENTAL CHANGE. THIRDLY, THE OBVIOUS REDUCTIONS IN PREMATURE DEATH WHICH CHARACTERIZED THE 19TH AND EARLY 20TH CENTURIES WERE ALL THE MORE EVIDENT BECAUSE THERE WAS SO MUCH ROOM FOR IMPROVEMENT.

THE SCIENTIFIC CHALLENGES IN DISEASE PREVENTION WHICH REMAIN, AND THERE ARE MANY, ARE LIKELY TO BE FAR MORE COMPLEX.

TODAY'S ILLNESSES AND INJURIES AND THE DISABILITIES TO WHICH THEY GIVE RISE ARE THE RESULT OF NUMEROUS INTERACTING FACTORS INCLUDING THE ENVIRONMENTAL AND BEHAVIORAL ASPECTS OF ILL HEALTH. AS A RESULT, THE SCIENTIFIC CERTAINTY THAT PROMOTING A CERTAIN "PREVENTIVE" ACTION WILL ACTUALLY BE OF NET BENEFIT TO CANADIANS AS A WHOLE IS FAR LESS THAN WAS THE KNOWLEDGE OF THE NEED TO KEEP A WOUND CLEAN. PREVENTION HAS BECOME A FAR MORE DIFFICULT UNDERTAKING THAN WE MAY AT ONE TIME HAVE IMAGINED.

SINCE NOT ALL HEALTH PROBLEMS ARE PREVENTABLE, OUR THIRD CHALLENGE IS TO ENHANCE THE ABILITIES OF INDIVIDUALS TO COPE WITH DISEASE, DISABILITY AND THE STRESS OF MODERN DAY LIVING.

TO MY MIND, OF THE THREE CHALLENGES I HAVE IDENTIFIED, THIS IS THE AREA WHERE THE MAJOR CONCERN IS TO DEVELOP KNOWLEDGE WHICH WE CAN THEN APPLY TO THE PROMOTION OF HEALTH. THIS IS FERTILE AREA FOR SCIENCE, PARTICULARLY FOR THE NEURAL, BEHAVIORAL AND SOCIAL SCIENCES.



PART OF OUR CONCERN WITH COPING IS DUE TO THE ASTONISHING RAPIDITY OF CHANGE WHICH SCIENCE HAS WROUGHT, PARTICULARLY IN THE LAST FEW DECADES. MANY PEOPLE WITHIN OUR SOCIETY HAVE ADAPTED TO THE NEW TECHNOLOGIES AND ARE FLOURISHING. ASPECTS OF OUR NEW WORLD HOWEVER, HAVE ALSO CREATE STRESSES WITH WHICH OTHERS ARE NOT ABLE TO COPE. POLLUTION, NOISE AND A LACK OF PERSONAL ABILITY TO CONTROL EXTERNAL FORCES ARE ALL FACTORS THAT CAUSE ENORMOUS STRESS. TELEVISION DOES NOT COMPENSATE FOR THE PERSONAL CONTACTS WHICH MANY INDIVIDUALS HAVE LOST. THE WORLD TODAY IS HARDER, LESS FORGIVING AND LESS SUPPORTIVE DESPITE THE EXTENSIVE SOCIAL POLICIES WHICH GOVERNMENT ATTEMPTS TO PUT IN PLACE.

THE TASK OF IDENTIFYING AND HELPING THOSE WHO ARE LIVING LESS THAN OPTIMAL LIVES IS BOTH A SOCIAL AND A SCIENTIFIC CHALLENGE.

ADDRESSING THE THREE MAJOR ISSUES IN HEALTH WILL REQUIRE THE USE OF A COMPREHENSIVE MIX OF STRATEGIES, THAT INCLUDES KNOWLEDGE DEVELOPMENT, RESEARCH AND PUBLIC EDUCATION. THE APPLICATION OF THESE STRATEGIES WILL BE DIRECTED TOWARDS THREE BROAD GOALS:

- 1) STRENGTHENING SELF-CARE PRACTICES, THAT IS, THE CARE PEOPLE PROVIDE FOR THEMSELVES WHEN THEY MAKE HEALTHY CHOICES ABOUT HOW THEY EAT, DRINK, DRIVE, KEEP FIT AND HANDLE ILLNESS;
- 2) ENCOURAGING SELF-HELP AND MUTUAL AID PRACTICES, BECAUSE





IT IS NEIGHBOURS, FAMILY MEMBERS, FRIENDS AND VOLUNTEERS WHO CAN PROVIDE THE ONGOING EMOTIONAL AND PRACTICAL SUPPORT THAT IS REQUIRED BY INDIVIDUALS AND FAMILIES DEALING WITH LONG-TERM DISABILITIES, ACUTE ILLNESS OR THE EVERYDAY STRAINS OF MODERN LIFE;

- 3) CREATING ENVIRONMENTS FOR HEALTH BY IMPROVING LIVING AND WORKING CONDITIONS, ESPECIALLY FOR THOSE WHOSE OPPORTUNITIES AND CHOICES MAY BE COMPROMISED BY GENDER, RACE, AGE, GEOGRAPHICAL LOCATION OR ECONOMIC STATUS. THIS CONCEPT MAY BE SUMMARIZED BY THE PHRASE "MAKING HEALTHY CHOICES THE EASY CHOICES".

SO FAR I HAVE DISCUSSED THE NEED FOR SCIENCE AND ITS POTENTIAL IN PUBLIC POLICIES FOR HEALTH, USING "ACHIEVING HEALTH FOR ALL" AS A BASIS FOR EXAMPLES. IN THE TIME REMAINING, I WOULD LIKE TO INDICATE SOME OF THE DIFFICULTIES WHICH I SEE FACING US AS WE TRY TO INTEGRATE SCIENCE, HEALTH AND PUBLIC POLICY.

#### ISSUES OF INTEGRATION

THESE DIFFICULTIES ARISE IN GENERAL FROM THE LACK OF PUBLIC UNDERSTANDING OF SCIENCE AND ITS ROLE. THEY LEAD ME TO THE MAJOR POINT THAT I WANT TO MAKE TODAY, THAT SCIENCE, BECAUSE OF ITS PIVOTAL ROLE IN SOCIETY, MUST PLAY A LARGER AND MORE DIRECT PART IN THE AFFAIRS OF SOCIETY. TO ENHANCE HUMANITY, SCIENCE MUST



ENDEAVOUR TO COMMUNICATE MORE -- TO GUIDE THE CREATION OF PUBLIC POLICY, TO EXTEND THE BENEFITS OF KNOWLEDGE TO ALL AND MOST IMPORTANTLY, TO WORK TOWARDS THE EFFECTIVE IMPLEMENTATION OF THE SCIENCE KNOWLEDGE WE NOW HAVE.

IN RETURN, PUBLIC POLICY MUST NURTURE SCIENCE, AND ALLOW OUR SCIENTISTS TO DEVELOP NEW LINES OF THINKING, THE TOOLS AND KNOWLEDGE UPON WHICH FUTURE MEANS OF PROMOTING HEALTH CAN BE BASED. BOTH SCIENCE AND PUBLIC POLICY MUST INVEST IN PEOPLE, BECAUSE, AT THE END OF THE DAY, PEOPLE WILL ALWAYS BE OUR MOST VALUABLE RESOURCE.

ONE CONCERN IS THAT, WHILE WE TALK OF SCIENTIFIC FACTS AND INFORMATION, SCIENCE IS NOT FREE OF VALUES OR OF HUMAN JUDGEMENT. THIS IS WELL UNDERSTOOD BY MANY SCIENTISTS, BUT NOT SO WELL ACCEPTED BY THE PUBLIC. THE RESULTS OF MANY STUDIES ARE INFLUENCED BY THE PARADIGMS, VALUE JUDGMENTS OR ASSUMPTIONS UNDERLYING THE RESEARCH WHICH GENERATED THE INFORMATION. HOW MUCH OF OUR UNDERSTANDING OF OUR SOCIETY IS FOUNDED ON AN IMPLICIT SET OF VALUES AND ASSUMPTIONS, AND ARE THESE VALUES AND ASSUMPTIONS CONSISTENT WITH THOSE OF SOCIETY?

A FURTHER DIFFICULTY IN LINKING THE PRODUCTS OF SCIENCE TO THE PUBLIC PROCESS ARISES FROM THE DIFFERENT WAYS THAT SCIENTISTS AND THE PUBLIC UNDERSTAND THE NUANCES OF MEANING IN EVERYDAY WORDS.



TAKE, FOR EXAMPLE, THE WORD "SAFE". A SCIENTIST RECOGNIZES THE WORD "SAFE" AS RELATIVE; THERE IS NO ABSOLUTE SAFETY. EXPERTS CAN RECOGNIZE THE HAZARDS OF TECHNOLOGY, AND CONSTANTLY MONITOR THE RISKS. HOWEVER, THOSE WHO ARE LESS EXPERT MAY REGARD THE WORD "SAFE" AS HAVING AN ABSOLUTE MEANING; A THING IS EITHER SAFE OR IT ISN'T. THE PUBLIC APPLIES COMPLEX TECHNOLOGY AS A PART OF EVERYDAY LIVING, THOUGH OFTEN WITHOUT A FULL UNDERSTANDING OF ITS CONSEQUENCES. WHEN WE TURN ON A SWITCH, START THE FAMILY CAR, OR TAKE SOME MEDICATION, WE EXPECT THAT ONLY GOOD WILL RESULT. WE FORGET THAT POWER SOURCES, MEANS OF TRANSPORT OR DRUGS ARE NOT WITHOUT THEIR OWN DANGERS, THOUGH WE TURN TO THEM BECAUSE THEY BRING REAL ADVANTAGES. WE FORGET THAT OUR USE OF TECHNOLOGY PLACES DEMANDS ON THE INDUSTRIES WHICH LIE BEHIND THEM, SOMETIMES MAKING IT NECESSARY FOR OTHERS TO TAKE RISKS OR CAUSE INSULTS TO THE ENVIRONMENT.

SCIENCE MUST NOT ONLY BE RELIABLE FROM A RESEARCH PERSPECTIVE, IT MUST ALSO BE SEEN TO BE RELIABLE BY ITS CONSUMERS, THE INTENDED BENEFICIARIES OF PUBLIC POLICY. THE PUBLIC MAY TAKE IT AS AXIOMATIC THAT A POLICY MUST BE KNOWN TO BE OF VERY CLEAR BENEFIT TO SOCIETY OVERALL BEFORE STEPS ARE TAKEN TO IMPLEMENT IT. THEY MAY THEREFORE DEMAND THAT SCIENCE ASSURE THEM THAT BENEFIT WILL RESULT, AND THAT ALL THE NEGATIVE POTENTIALS HAVE BEEN ACCOUNTED FOR.





THE NATURE OF SCIENCE AND OF SOCIAL CHANGE PRECLUDES THIS TYPE OF ABSOLUTE PREDICTION. WHILE THE PUBLIC MAY DEMAND SUCCESS FROM PUBLIC POLICIES, PERHAPS THEY SHOULD BE REGARDED AS EXPERIMENTS RATHER THAN AS RECIPES.

HAVING RECOGNIZED THIS, I WOULD LIKE NOW TO SWITCH MY FOCUS TO THE PUBLIC ASPECTS OF THE TRIANGLE OF SCIENCE, HEALTH AND PUBLIC POLICY.

IT IS EVIDENTLY NOT POSSIBLE FOR EACH ITEM OF PUBLIC POLICY TO HOLD ONLY GOOD FOR ALL MEMBERS OF A SOCIETY. HOWEVER IT MUST BE AGREED THAT EACH ITEM SHOULD BE OF NET BENEFIT TO CANADIANS AS A WHOLE, AND THAT ALL CANADIANS SHOULD BENEFIT FROM AN ENSEMBLE OF HEALTHY PUBLIC POLICIES.

AS POLICY IS INITIATED, IT IS SCRUTINIZED MOST CLOSELY BY THE MANY AND VARIED COMPONENTS OF SOCIETY. EACH ITEM OF NEW POLICY IS THEREFORE VIEWED IN RELATIVE ISOLATION. ITS BENEFITS AND RISKS TO INDIVIDUALS AND GROUPS ARE ANALYZED WITH AT BEST LIMITED REFERENCE TO THE OVERALL STATUS OF PUBLIC POLICY AND THE NEEDS OF THE COUNTRY AS A WHOLE. NEW POLICY THEREFORE TENDS TO BECOME A BATTLEGROUND FOR SPECIAL INTEREST GROUPS, EACH WAGING A POLITICAL WAR TO WIN THE SUPPORT OF THE GENERAL PUBLIC. ONE FACTOR IN THIS DEBATE IS THAT THE BENEFITS OF EXISTING PUBLIC POLICY ARE REGARDED AS RIGHTS BY THE INTERESTED PARTIES, AND THE SENSE OF INDIVIDUAL RIGHTS AND FREEDOMS IS VERY STRONG IN OUR



SOCIETY. HOWEVER, WHILE RIGHTS CAN WELL BE DEMANDED, THEY CAN ONLY COME INTO EFFECT IF OTHERS IN SOCIETY ARE PREPARED TO PAY THE INHERENT COSTS.

I BELIEVE THAT MY POLITICAL STRUGGLE TO PREVENT THE THOUSANDS OF SMOKING-RELATED ILLNESSES AND DEATHS IN CANADA EACH YEAR, IS A CASE IN POINT.

I NOTE THAT THERE HAVE BEEN OBJECTIONS TO MY PROPOSAL TO BAN TOBACCO ADVERTISING ON THE GROUNDS THAT IT CURTAILS FREE SPEECH. I REJECT THAT ARGUMENT FOR SEVERAL REASONS. FIRST, FREE SPEECH IS NEVER AN ABSOLUTE; YOU ARE NOT FREE, FOR EXAMPLE, TO FALSELY SHOUT "FIRE" IN A CROWDED THEATRE. IN SUCH AN EVENT, THE RESULT WOULD BE MORE HARMFUL THAN LIMITING THE SPEECH. THE SITUATION WITH RESPECT TO TOBACCO ADVERTISING IS PRECISELY THE SAME: THE DAMAGE IT CREATES IS MORE OF A THREAT TO SOCIETY THAN THE LIMIT PROPOSED.

WE CAN BE EXCUSED FOR REJECTING THE ARGUMENT THAT ADVERTISING DOES NOT INCREASE TOBACCO USE. IT IS ONLY REASONABLE, IN FACT, TO ASSUME THAT ADVERTISING DOES HAVE AN IMPACT ON PEOPLE'S BEHAVIOUR. SURELY, IF IT DID NOT, THE TOBACCO COMPANIES WOULD NOT SPEND MILLIONS OF DOLLARS USING ADS TO PERSUADE US TO BUY THEIR PRODUCTS.

I DON'T BELIEVE THAT SOCIETY IS PREPARED TO PAY THE HUMAN



COSTS OF TOBACCO USE AND THE EFFECTS OF SIDESTREAM SMOKE ON THE HEALTH OF OTHERS. HAVING SAID THAT, I AM FULLY CONVINCED THAT IT IS ALSO THE RESPONSIBILITY OF PUBLIC POLICY TO ENABLE CANADIANS WHO GROW AND MANUFACTURE TOBACCO TO FIND ALTERNATIVE CROPS AND EMPLOYMENT OPPORTUNITIES.

THE COMPREHENSIVE "SCIENTIFIC" EVIDENCE ON TOBACCO USE WHICH HAS BEEN BUILDING SINCE THE 1950'S FORMS THE CORNERSTONE OF THE PUBLIC DEBATE ON TOBACCO POLICY. UNFORTUNATELY, THIS IS NOT ALWAYS THE CASE. THOSE PROMOTING SPECIFIC VIEWPOINTS OFTEN TAKE ONLY THOSE DATA WHICH SUPPORT THEIR VIEWS, AND EITHER NEVER MENTION, OR ELSE TRY TO DISCREDIT, THE CONTRARY EVIDENCE. FURTHER, THE COMPLEXITIES AND NUANCES OF THE SCIENTIFIC DATA ARE OFTEN LOST IN THE SIMPLIFICATIONS EACH SIDE USED TO MAXIMIZE ITS ADVANTAGES. FREQUENTLY, SCIENTIFIC DETAIL GETS LOST IN THE PUBLIC ARGUMENT.

THIS LEADS ME TO TWO OBSERVATIONS. FIRST, PUBLIC POLICIES MUST NOT ONLY UNEQUIVOCALLY ACT TO FURTHER THE INTERESTS OF CANADIANS AS A WHOLE, BUT THEY MUST ALSO BE SEEN BY THE PUBLIC TO BE OF GENERAL ADVANTAGE. SECOND, THE PROCESS OF PUBLIC VALIDATION OF PROPOSED POLICIES USES SCIENCE, BUT WITHOUT THE CAVEATS AND NUANCES WHICH THE SCIENTIST KNOWS ARE NECESSARY IF THE DATA ARE TO BE USED AT ALL. SCIENTISTS THEREFORE MAY DROP OUT OF THE DEBATE AT THE MOST CRUCIAL PHASE, OR MISTRUST THOSE OF THEIR COLLEAGUES WHO TRY TO STAY IN THE DISCUSSION.





SCIENTISTS MUST BE STRONG ADVOCATES FOR A POSITIVE, ECOLOGICAL VIEW OF HEALTH WITHIN GOVERNMENT. THEY MUST PRECIPITATE THE DEBATES THAT WILL KEEP HEALTH HIGH ON THE AGENDA OF POLITICIANS AND PROGRAM MANAGERS.

THIS BRINGS ME TO THE ROLE OF GOVERNMENT IN THE DEVELOPMENT OF HEALTHY PUBLIC POLICY.

BUILDING HEALTHY PUBLIC POLICY INVOLVES EXERCISING INFLUENCE AND ESTABLISHING LINKS ACROSS THE SPECTRUM OF GOVERNMENT POLICY AND THAT OF OTHER INFLUENTIAL BODIES SUCH AS TRADE UNIONS AND SOCIAL MOVEMENTS. THERE MUST BE STRUCTURES AND PROCESSES WITHIN GOVERNMENT THAT ENCOURAGE AND FACILITATE INTERSECTORAL ACTION FOR HEALTH.

EQUALLY IMPORTANT, HEALTHY PUBLIC POLICY REQUIRES THAT THERE BE MEANS FOR INFORMED PUBLIC PARTICIPATION IN PRIORITY SETTING, IN STRATEGIC PLANNING AND IN DECISION-MAKING. TO SUCCEED, POLICY MUST BE MADE BY THE PUBLIC, FOR THE PUBLIC AND IN PUBLIC.

#### INVESTING IN PEOPLE

THIS BRINGS TO ME LAST POINT OF DISCUSSION AROUND THE INTEGRATION OF THE TRIANGLE OF HEALTH, SCIENCE AND PUBLIC POLICY.



OUR MUTUAL MISSION IS TO FIND WAYS OF SHAPING SCIENCE AND PUBLIC POLICY SO THAT THEY COME TO GRIPS WITH EMERGING HEALTH PERCEPTIONS AND REALITIES.

THIS MEANS MAKING SOCIAL POLICY RESPONSIVE TO DEVELOPING IDEAS OF WELL BEING. THIS WILL REQUIRE THAT WE LISTEN TO THE PEOPLE AND WORK TO ENABLE THEM TO IMPROVE THEIR OWN HEALTH STATUS AND INCREASE THEIR SUPPORT FOR OTHERS. IT WILL REQUIRE THAT WE INVEST IN SCIENCE AND HAVE FAITH THAT OUR SCIENTISTS' DISCOVERIES WILL LEAD US FORWARD.

THE QUALITY OF LIFE IN THE FUTURE WILL DEPEND ON THE QUALITY OF OUR THINKING AND OUR ABILITY TO SHARE THAT THINKING.

CANADIANS RELY ON THE SCIENTIFIC COMMUNITY TO HELP GOVERNMENT DEVELOP AND IMPLEMENT GOALS WHICH WE SHARE. I ASK YOU TO CONTINUE TO GENERATE NEW KNOWLEDGE, NEW CHALLENGES, NEW QUESTIONS AND NEW ANSWERS FOR SOCIETY. THIS IS ESSENTIAL TO OUR FUTURE AS A COUNTRY, NOT ONLY AS REGARDS OUR ABILITIES TO ACHIEVE HEALTH FOR ALL, BUT ALSO FOR THE MAINTENANCE OF THE ESSENTIAL ROLE OF SCIENCE IN DEVELOPING OUR NATIONAL CULTURE.



IN 1960, AT A DARTMOUTH CONVOCATION ON ISSUES OF CONSCIENCE  
IN MODERN MEDICINE, DR. PENFIELD MADE THE FOLLOWING REMARKS:

"IN SPITE OF ALL OUR DISQUIETING TRIUMPHS IN  
THE FIELD OF NATURAL SCIENCE, IT'S  
ASTONISHING HOW LITTLE MAN HAS LEARNED ABOUT  
HIMSELF, AND HOW MUCH THERE IS TO LEARN. HOW  
LITTLE WE KNOW ABOUT THIS BRAIN WHICH MADE  
SOCIAL EVOLUTION POSSIBLE, AND OF THE MIND.  
HOW LITTLE WE KNOW OF THE NATURE AND SPIRIT  
OF MAN AND GOD. WE STAND NOW BEFORE THIS  
INNER FRONTIER OF IGNORANCE. IF WE COULD  
PASS IT, WE MIGHT WELL DISCOVER THE MEANING  
OF LIFE AND UNDERSTAND MAN'S DESTINY"

WILDER PENFIELD RECOGNIZED THE LINKS BETWEEN SCIENCE AND THE  
BROADER SOCIETY. TODAY, AS WE GRAPPLE WITH THE FUTURE, WE NEED  
TO KEEP HIS EXAMPLE AND BREADTH OF VISION FIRMLY IN MIND.





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**health  
and welfare  
canada**

**sant  et  
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canada**

Office of the Minister  
The Honourable Jake Epp

Cabinet du ministre  
l'honorable Jake Epp

AN ADDRESS BY  
THE HONOURABLE JAKE EPP  
MINISTER OF NATIONAL HEALTH AND WELFARE

TO  
THE GENERAL ASSEMBLY  
THE UNITED NATIONS  
NEW YORK

OCTOBER 20, 1987



Health  
and Welfare  
Canada

Sant  et  
Bien- tre social  
Canada

Canada



Mr. President,

I would like to take this opportunity to express my admiration for the way you have conducted this debate. I am sure that everyone will agree that you have shown great skill in guiding us in this special session. The Secretary-General must also be thanked for his summary of the AIDS situation throughout the world. His lucid description has set the tone for our debate.

It is hard to believe that less than 10 years ago, few people had heard of Acquired Immunodeficiency Syndrome. No one could imagine a disease of such magnitude. While there have always been deadly diseases, there had developed, over the last few decades, a faith that the skills of doctors and medical researchers would eventually protect us. Think of the great strides that we had already made, such as the eradication of smallpox.

We are now faced with a disease against which, for all its efforts, modern science has made little headway. I do not underestimate the brilliant work already done by doctors and researchers. Extraordinary advances have already been made in research into this disease. In just a very short time scientists have developed an understanding of the complex nature of the disease. Still, it is clear that it will take many years and much effort before we can hope to control AIDS through medical techniques.

It is obvious that AIDS has reached such a height of public concern because of the various ways that one can become infected with it. As we well know, many victims of AIDS have been infected by the use of tainted blood and blood products.



How many millions of people have been saved from the ravages of deadly diseases by means of blood transfusions or intra-venous injections with vaccines? With immunization programmes sponsored by the WHO and UNICEF, these immunizations would eventually be available to all. Now, the fear of AIDS has put these programmes into jeopardy. People are justifiably concerned that they may receive the AIDS virus from reused needles. This fear of AIDS could lead to an undermining of the great efforts which have already been made to control other diseases.

However, as we are all aware, the most common way by which AIDS is spread is intimate contact. This is the source of our greatest concerns. Certainly, there have been sexually transmitted diseases before. But never has there been one of such magnitude and danger. We must recognize that the sexual transmission of AIDS is not restricted to any particular group, but that all sexually active people are potentially its victims.

Opinions have been expressed that there have been very few victims of AIDS so far. There is some truth in this. In Canada, which has one of the highest rates of AIDS in the world, there have been only about 650 deaths. Yet, estimates show that this is only the tip of the iceberg. What is truly frightening is that we do not know the full magnitude of the disease. Some experts have concluded that everyone who is infected with AIDS will die of it. When we think of the numbers who already are infected by the disease, and how far it could spread, we all must face the fact the effect of the disease will be medically and economically devastating. The cost of caring for AIDS victims will be an enormous burden, even for the most developed countries.





Furthermore, it is clear that the effects of AIDS will go beyond just the deaths of tens of thousands. It has the potential to upset the social and economic fabric of many countries which will likely lose some of their most economically productive members. In addition, as the number of AIDS victims grows, the cost of caring for them may swamp other equally important health care programmes. We must not forget that there are other serious health care problems, aside from AIDS, which must be addressed.

For the immediate future, we face the problem of the fear which has resulted from the misinformation being disseminated about AIDS. Over the last few months, we have seen many examples of AIDS victims suffering discrimination. Increasingly, those who are AIDS sufferers are being shunned by other members of society. We must ensure that these people are not excluded and we must give them such care as is possible.

Just as we cannot isolate the individuals AIDS sufferers, we must not cut off those countries where it seems that the AIDS virus has struck the hardest. We must help them deal with the situation. The AIDS pandemic is should be the occasion for greater cooperation among us.

Clearly, more than words are needed. AIDS will have to be dealt with in a variety of different activities. Research efforts must be properly balanced with public education. This is the approach which Canada has taken to deal with the AIDS pandemic.

AIDS cases were first reported in Canada in 1982. Since that time, 1200 people have developed AIDS. Sixty-seven percent (67%) of AIDS sufferers are between 20 and 49. Over 82% of



victims are homosexuals or bisexuals. By the end of 1991, there may be as many as 6700 AIDS cases in Canada. It is estimated that there are between 50 000 and 100 000 infected people in Canada.

Blood and blood products screening began in November 1985. After the first year of screening, 211 of 1.2 million samples contained the AIDS virus antibody. We are confident that the Canadian blood and blood product supply is safe from AIDS.

Once the full extent of the AIDS danger was evident, we, in Canada, were not slow to react. Between 1982 and 1986 \$2.6 million had been spent on AIDS research by the Canadian government. In 1986, I announced a \$39 million, five year programme of which over \$22.5 million will be allocated to various research projects. Canadian government research will concentrate on:

- a) the use of epidemiological studies of population groups as a means to determine the extent and progression of infection;
- b) the improvement of diagnostic techniques through the use of bio-technology;
- c) the development of a rapid test to identify the presence of virus;
- d) the development of an effective vaccine, which is fundamental to any long-efforts to control the spread of the virus;
- e) immunological studies in individuals with AIDS or related infection; and
- f) socio-economic studies of the effects of AIDS.



To ensure that its plans are properly implemented, the government of Canada has set up Federal Centre for AIDS. This organization brings together all the AIDS-related scientific and medical related expertise within the federal government. The Centre, which has been designated a WHO AIDS Collaborating Laboratory, will coordinate epidemiological studies with regard to AIDS and will also serve as a source of technical and scientific information for laboratories across the country. Additionally, research will be done by non-governmental organizations, such as universities and hospitals, with the assistance of federal and provincial funding.

In Canada, we recognize that it will be many years before there is a cure for AIDS. We know that even a vaccine is a long way off. Clearly, at present, and for the foreseeable future, the only means available to slow the spread of AIDS are education programmes. The national government has allocated \$3.7 million to the Canadian Public Health Association for a national AIDS Education and Awareness programme which includes intensive multi-media educational projects as well as seminars, provision of written materials, and course curricula. Much of the funding provided will go to support community-based AIDS organizations to provide education and services to all parts of Canadian society, including those who are at the most risk.

To ensure that the government of Canada was receiving the best advice possible on all aspects of AIDS, the National Advisory Committee on AIDS was formed in 1983. As the pandemic grows, there will be a need to address the many social, legal and moral issues which will arise. Experts in those disciplines have been included in the Advisory Committee.





Under our federal system, the provinces are responsible for all aspects of education, as well as health care delivery. Therefore, various provincial and territorial governments are establishing their own preventive awareness programmes.

The key to all the educational efforts across the country is that they provide intelligible, reliable information. Handled with delicacy and taste, these programmes can provide Canadians with information about the dangers they face and will familiarize them with the methods available to reduce those risks.

In my opinion, we, in Canada, are doing our utmost to bring AIDS under control within our own borders. However, we cannot do the job alone. Canadians recognize that it is urgent that international efforts are undertaken to deal with the pandemic. Canadian scientists and doctors have worked with those of many other countries. In 1989, Canada will host the 5th International Conference on AIDS, whose theme will be partnership, both within and between countries, and it will focus on the social and economic aspects of AIDS.

We welcome this debate because it is an opportunity to discuss the various dimensions of AIDS, especially the need for international cooperation. This is why we were amongst the first to co-sponsor the draft resolution on AIDS and to urge others to co-sponsor it. My presence here is indicative of Canada's willingness to cooperate with other countries to try to manage the pandemic.

Above all these things, we have shown our strong commitment to participate in the global campaign against AIDS by our strong support of the World Health Organization's Special



Programme on AIDS as the focal point of international efforts against AIDS. Last May, the federal government contributed \$5 million to this programme, an amount which remains the largest single contribution. We firmly believe that the WHO Special Programme on AIDS is essential if we are going to control the AIDS pandemic around the world. Therefore, it is vital that it be supported and fully funded.

The Special Programme has been endorsed by countries from all regions. Last May, the leaders of the Seven Leading Industrial Nations endorsed the work of the Special Programme. Only last week, in Vancouver, the Commonwealth Heads of Government stated their willingness to cooperate with the WHO. This support is not surprising. It has been earned by the extraordinary work done by Dr. Jonathan Mann and his staff. Since February, they have, while occupied with the organization and planning of the Special Programme, nonetheless been able to advise many countries about the AIDS pandemic. The Special Programme has already released a number of studies which are of great use to all countries.

One of Special Programme's most important roles is to gather information about AIDS. It is essential that we have a free and accurate exchange of information regarding all considerations of the pandemic. This is a responsibility for which the Special Programme is especially suited. In addition, as the international focal point, the Special Programme will provide the necessary coordination and collaboration to ensure that countries do not duplicate each other's work.



The Special Programme will be able to be a catalyst for cooperation between countries. Furthermore, it will be able to build the consensus on issues to avoid conflicts which can only hamper efforts to deal with the pandemic. By providing guidelines of various questions, such as AIDS and breast feeding, the Special Programme helps alleviate some of the fears which the pandemic is causing.

The other major role which the Special Programme has is to assist countries in the preparation of their national strategies to fight AIDS. National strategies of prevention and control are essential if we hope to stop the spread of AIDS. The Special Programme can provide the expertise to put the necessary programmes in place.

It is clear that the Special Programme on AIDS will play a central role in any successful campaign to control AIDS. I urge all countries to cooperate fully with the work of this programme. All countries must face the serious consequences which will result from AIDS, if it is left unchecked. Long-range health needs should not be sacrificed for short-term economic gains.

Mr. President,

We are faced with a deadly test and I believe that the next five to ten years are the most crucial. I believe that our countries, working together with the WHO have the tools to meet the challenge. The work already done by researchers convinces me that it is only a matter of time before there is a vaccine. However, we must accept that a cure is a long way off. For the





foreseeable future, we only have our teaching skills to slow the growth of the AIDS pandemic. Delicate subjects, those which we generally would prefer to not discuss in public, will have to be addressed. Cooperation and collaboration is vital and this will be one of the WHO's major roles.

We can only succeed in our efforts to control the pandemic if each of us recognizes that AIDS is a threat to the social and economic fabric of all our countries. The AIDS pandemic knows no borders, nor can it distinguish the nationality of its own victims. We must avoid casting blame on any one group of people. We are all in this together. The defeat of AIDS could be an example of people working together, regardless of national origin, race or creed. Or it could be an expression of how national divisions and mindless prejudice can condemn millions of people to horrible deaths. We must make this decision soon for we have little time left.



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Office of the Minister  
The Honourable Jake Epp

Cabinet du ministre  
l'honorable Jake Epp

HEALTH CARE REFORM: THE CHALLENGES FOR NORTH AMERICA

KEYNOTE ADDRESS

BY

THE HONOURABLE JAKE EPP

MINISTER OF NATIONAL HEALTH AND WELFARE

TO THE

AMERICAS SOCIETY/CANADIAN AFFAIRS

1987 FALL CONFERENCE

PLAZA HOTEL, NEW YORK CITY

NOVEMBER 18-19, 1987

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Mr. Chairman, ladies and gentlemen, I am pleased and honoured to be invited to join you tonight and I want to thank you for this opportunity to speak about Canada's health care system.

In Canada, as in other industrialized countries, we have reached a point where we must take stock of our past accomplishments. We must address emerging issues that directly affect our capacity to provide health care services to our population at a cost both the nation and the individual can afford. We must make choices that will determine the future orientation of our health care system.

The theme of this conference - Health Care Reform: The Challenge for North America - is therefore one we can all relate to. I want to commend the Americas Society for their choice of this topic and the timeliness of this public forum between our two countries.

It is always important for countries and cultures such as ours to exchange ideas and experiences. This is especially true at times when the stage is set for new cooperative ventures. Not surprisingly, what I have in mind is the proposed Canada-U.S. free trade arrangement.





The Canadian Government is convinced that free trade between our countries will be of enormous benefit to both Canada and the United States. I raise the issue of Trade, however, because of its relevance to the subject of health care in North America.

First, it was suggested throughout the free trade negotiations that Canada's social programs were at risk of being sacrificed to an agreement. The evidence is now clear, as were the assurances all along, that health care and our other social programs, are not at risk in a free trade arrangement.

Why? Because the free trade proposal is between two sovereign countries. As I shall explain later, our own brand of health care is fundamental to our sovereignty and to the Canadian way of life.

Second, free trade is about removing the barriers that stand in the way of increased prosperity and economic security for Canada, and presumably for the United States. The people I serve as Minister of Health and Welfare have a very real interest in securing our economic foundations in order to safeguard the programs of social policy that are so important to us.



For economic and social reasons, free trade among nations is, I believe, an inherently good thing. It brings the promise of mutual benefit, when governed by fair rules, and it encourages the extension of good will among nations. In Canada, a healthy economy - vigorous, dynamic, and growing - has always been the bedrock on which our social programs stand. Free trade and its benefits, will enable them to stand more securely.

The third observation about free trade and health care is in many ways the one message I would like you to remember from my remarks. Some exponents of Canadian nationalism claim to fear that a closer association with the United States will lead to a gradual but inevitable end of our particular system of health care.

I do not believe that will happen. In fact, I am convinced that closer ties in trade will increase Americans' knowledge of Canadian health care. This in turn may lead to the United States adopting Canada's approach, because I think our system is better!



In the market place of ideas and of public policy, the more Americans get to know about Canadians, the more they will recognize our brand of health care as one of our finest exports.

As evidence for my case, I will spend the next few minutes discussing, from a federal perspective, the nature of the Canadian health care system and how much it costs. Second, I will identify some of the challenges facing the system. Americans here tonight will no doubt identify with the issues that I will raise as they are closely related to continuing changes in the demography and health status of the population that are occurring on both sides of the border. My third point will focus on various options that Canadians see as viable alternatives to the dilemma of providing quality and cost-effective health care services to all our citizens.

The national health insurance system in Canada is truly bipartisan, such is its support among Canadians. In 1958 a Conservative government enacted the Hospital Insurance and





Diagnostic Services Act (HIDS) to cover hospital services. Building on that achievement, a parallel piece of federal legislation, the Medical Care Act, was passed in 1966 by a Liberal Government to encompass physician services as well.

Given that the Canadian constitution assigns the primary responsibility for health matters to the provinces, the federal government, through this legislation, exercised its constitutional spending powers by offering the provinces substantial contributions towards the cost of insured hospital and physician services. It also established certain basic criteria that the provinces had to meet to qualify for these contributions. These criteria, which form the cornerstones of our system, provided that all necessary medical and hospital services would be available to every resident of a province on uniform terms and conditions.

The provinces gradually subscribed to the national program and, by 1971, all had implemented publicly sponsored health insurance schemes covering hospital and physician services.

In 1984, the Hospital Insurance and Diagnostic Services Act and the Medical Care Act were repealed and replaced by the Canada Health Act. The nature and scope of the system



remained unchanged under this Act. The federal government's aim in passing this new enabling legislation was to reaffirm its commitment to its original guiding principles and to provide a mechanism to promote the provinces' compliance to the federal criteria that consist of:

- reasonable access to medically required services unimpeded by charges at point of service,
- comprehensive coverage for medically required services,
- universality of population covered,
- portability of benefits within Canada and abroad; and
- public administration of the health insurance plan on a non-profit basis.

For Canadians, this means that medically necessary hospital services, physician services, and certain surgical dental procedures are available to everyone on a prepaid basis.

The philosophical underpinning of this principle is a recognition that the burden of costs may be catastrophic to the individual or family. Because illness, accident or disability are no respecters of persons, Canadians have chosen the route of taxation rather than direct charges to pay for their health care.



Hospital services include in-patient care at the standard ward level, unless private or semi-private accommodation is medically necessary, and all necessary drugs, biologicals, supplies and diagnostic tests, as well as a broad range of out-patient services.

Physician services cover all medically required services rendered by medical practitioners in hospitals, clinics or physicians' offices where services are rendered.

Both extra-billing and user charges are discouraged by the Canada Health Act, and are subject to dollar-for-dollar deductions from the federal contribution to a province's health care insurance program. These forms of direct charges are fees charged to patients for insured physician and hospital services, and are not recoverable from the provincial plan. Deductions were made from the contributions to several provinces after the passage of the Canada Health Act but all of these deductions were subsequently refunded following provincial action to eliminate such charges.





While extra-billing and user charges are subject to deductions, the provinces are allowed patient charges for chronic care to cover the costs of accommodation and meals for persons who are more or less permanently resident in a facility.

Within these parameters, and in line with the constitutional position, each province is responsible for administering its own plan. This flexibility is exercised in a number of areas.

For instance, provinces can rule on whether services beyond those of the national program are covered under this plan. All provinces provide such additional benefits which may include drug coverage, assistive devices, dental care, chiropody and physiotherapy.

Physicians' remuneration and hospitals are also regulated by the province. The predominant method of payment for physicians is on a fee-for-service basis, the payment schedule being negotiated by the province and the representative physician association.



Hospitals are, for the most part, owned and operated on a non-profit basis by voluntary agencies, municipalities and other institutions. The majority of hospitals operate under a global budgeting system that typically reflects government-set staff/patient and bed/population ratios. Another consideration in establishing a hospital's budget is the relative efficiency of its operations and year-over-year changes in the volume or mix of services provided.

An important feature of Canada's approach to hospital budgeting is the separation of operating expenses and capital spending. Arrangements for funding hospital construction costs or equipment acquisitions vary considerably across the different provinces.

You may well wonder how the system itself is financed and how much it costs.

On the financing side, the federal government's contributions to the provinces for insured health services are calculated accordingly to the provisions of a 1977 Act. Under this legislation, provinces are entitled to equal per



capita contributions which are annually escalated and related to changes in Gross National Product. These federal health contributions to the provinces consist of both a cash transfer and an equalized tax transfer.

The provinces, in turn, raise their portion of the costs through health insurance premiums, sales tax, other provincial revenues, or by a combination of these methods.

Since 1977, federal funding for an extended health care services component was added to assist in the development of institutional and home care, primarily for the elderly.

As for the costs, in 1985, total yearly health spending in Canada by all sources, public and private, amounted to approximately \$40 billion. Currently, the federal contribution is \$12.5 billion or \$490 per capita, \$1.2 billion of which is directed to the extended health care services segment.

In terms of the percentage of national economic output allocated to the health sector, Canada ranks relatively well with 8.5% of GNP, compared to the United States at 10.6%, Sweden at 9.4%, and 6.0% for the United Kingdom.





Health Care financing and expenditures are recurring themes in any debate centering on the health care system. Views differ on whether the system is adequately financed and whether our expenditures are absorbing a disproportionate amount of our resources. I believe, however, that the system is financially sound.

These few preceding points serve to demonstrate in very broad strokes how the Canadian system works. As you can see, it can be compared to a mosaic of twelve distinct plans through which run some common threads. As I mentioned, the system has evolved gradually. It has also been influenced by social and political forces our country has faced in the course of its history. In particular, the insistence on unimpeded access has faced considerable challenge in the 80s from the providers of medical care and some provinces. Yet its popularity with the public is well established and is reaffirmed consistently in opinion polls. For Canadians, universal access to needed hospital and medical care, is a public ethic - a value that any national government is called upon to respect and secure.



At this time, the Canadian system does not need reform in the literal sense. Its foundation and its basic premises have consistently been reinforced over a period of several decades and are firmly entrenched. Our system provides excellent care to all our residents on a fully prepaid basis, imposes no upper dollar limits on coverage, and this is achieved at a cost the taxpayers and the country can afford.

We do, however, have our challenges, though ours may be somewhat different from those faced in the United States. To ensure that we continue to provide quality care at reasonable costs as we leave the 80s, we must make some adjustments in certain areas.

We face increasing demands on our health care system. There are three principle examples.

The increasing proportion of elderly citizens, present and future, means additional pressures and responsibilities for our health care system. Statistics indicate that older people utilize health care services disproportionately in terms of their numbers in the general population. Yet we



know that individuals over 65 remain physically and mentally active and that the incidence of chronic conditions and the need for more frequent and intensive health care services tend to occur in older cohorts (85 and over). This suggests that there is a need to develop support systems in the community to shift the emphasis away from institutionalized care.

Medical knowledge has skyrocketed in the past ten years. We have seen a marked growth in areas such as neonatal care, transplantations, and reproductive technologies. Advances in medical technology are proving to be not only very expensive but they are fostering a natural demand in communities, both large and small, for access to the most advanced diagnostic and treatment technologies. There is, of course, a valid argument that certain expensive high technology can be cost-effective in the long run.

New health hazards and diseases such as AIDS are a significant test of our research, care and treatment capabilities.





Expensive life-saving procedures and sophisticated technology not only have financial implications but also moral and ethical ones. We must ask ourselves if we are raising false expectations about what the system can actually and realistically do for people. As the demand for and the costs of these interventions increase, difficult decisions may have to be made in terms of effectiveness, when they should be used, and for whom. In principle, we should be concerned about humankind's tendency to let our technology outstrip our capacity to use it wisely.

Answers to such questions are not obvious or easy. Difficult choices will have to be made. Health care providers will require guidelines in making decisions that directly affect the care and treatment they provide.

I believe that there are essentially two vehicles for dealing with health care needs and the containment of health care costs: alternative forms of health care delivery and an emphasis on health promotion and disease prevention.



One of the advantages of the Canadian system is that the provinces and territories can meet local needs by establishing their own programs, in conformity with federal conditions. This has permitted a number of provinces to develop alternative innovative approaches to the provisions of services.

In Quebec, the health reform in the 70s emphasized decentralization and public participation in the delivery of health services through the creation of local community health centres across the province. In 1987, there are 153 such community health centres which are responsible for all the social and health needs of a given population and provide a multidisciplinary approach to the delivery of services.

In New Brunswick, the "extramural hospital" concept is used to provide hospital services to patients in their own homes under a physician's care. Under that organization, a central administration is responsible for service delivery units across the province that provide hospital services to patients in their homes under a physician's care.



In some provinces, primary care treatment facilities are being strengthened in the community based on a team approach and the integration of non-medical or para-medical personnel. More emphasis is placed on comprehensive geriatric care and on viable alternatives to institutionalization especially for the aged. Maintaining seniors in the community can reduce costs and enhance their quality of life.

One approach is to release hospitalized patients earlier whenever possible and ensuring that community and home-based services are in place to provide assistance during convalescence.

Another is to develop ambulatory and emergency care facilities which will reduce dependence on full-scale hospitals.

In our search for more efficient and cost effective delivery models, can we learn from the experiences of other countries such as yours? I think we can. Two concepts in use here in the United States, are of particular interest to Canadians.





The Health Maintenance Organization, in which participation is optional but the fee-for-service system is replaced by an overall budgeted system. A variation of this concept is in use in Ontario. The province's Health Services Organizations (HSO) are an alternative for fee-for-service medicine where providers of health care are remunerated on a capitation basis.

The second concept I have in mind here is the Diagnostic Related Groups, one of many patient classification systems in the U.S., in which the costs for treatment in hospitals and, presumably other health institutions, can be tracked by a system of establishing various groups of diagnosis. In Canada, the Kingston General Hospital has been the site of a pilot caseload measurement and costing project adapted from the D.R.G.'s concept. The distinguishing feature of this Canadian experiment referred to as "case mix management" is that we have added a severity of illness measurement to better reflect the different level of resource output necessitated by the severity of each diagnosis.

The second vehicle that addresses concerns about health care needs and costs is health promotion and disease prevention.



On November 18, 1986, on the occasion of the first International Conference on Health Promotion held in Ottawa, I released a paper titled "Achieving Health for All - A Framework for Health Promotion". This paper outlines three major challenges that have not been adequately dealt with through current policies and health care practices. These include the need to reduce inequities in health, to increase our prevention efforts and to enhance people's capacity to cope with chronic conditions, disabilities and mental health problems.

In relation to inequities of health, we are confronted with a set of interrelated issues that centre on individuals themselves.

Universal access to health care, in itself, has not been sufficient to ensure everyone an equal or comparable level of health. In Canada today, a man in a high income bracket can expect to live some 6 years longer than a man with a low income; women with a high income can expect 8 more disability-free years than women in the low income group. Groups of people are at a disadvantage because of certain social, geographical or ethnic factors.



There is little doubt that universal access to health care has been instrumental in achieving a healthier population in Canada. It is also clear that we have reached the "flat-of-the-curve" - the point beyond which increased utilization or funding of health services will not result in a discernible improvement in individuals' health status.

The general consensus is that further benefits will arise out of lifestyle and environmental changes as well as a concerted effort to reduce existing inequities.

This brings me to the second challenge, to increase our prevention efforts. Since the early 1970s we have had impressive successes in encouraging people to change their lifestyles - to exercise, to eat well and to follow a physician's instructions. Yet significant prevention issues persist and new ones arise.

It is for this reason that the Canadian Parliament has before it legislation to ban the advertising of tobacco: the single largest force in preventable disease.

The same basic principle underlay the recent effort of the Government of Canada in dealing with drug abuse, child sexual abuse, and impaired driving.





Not all health problems can be prevented. And what we can't prevent, we must learn to live with. This brings us to the third challenge: enhancing coping - with disease and disability and with the stress of modern-day living.

Enhancing coping does not necessarily mean more health care services. It means enabling people to manage their health, to remain autonomous in their decisions, and to meet their own aspirations for well-being.

It means that those within the institutional sector are going to have to look increasingly at the broader context of the total health care system and the health of the population for which they are providing these services. And it means that policy makers must place renewed emphasis on three broad goals.

First, we must strengthen self-care practices, that is, the care people provide for themselves when they make healthy choices about lifestyle.



Second, we need to encourage self-help and mutual aid practices, because neighbours, family members, friends and volunteers can provide the ongoing emotional and practical support required by individuals and families dealing with disabilities, illness or the strains of modern life.

Third, we must work toward creating environments for health by improving living and working conditions, especially for those whose opportunities and choices may be compromised by gender, race, age, geography or economic status.

Contemporary challenges require contemporary solutions.

Health care is all about improving the health of our citizens. Health care policy is all about reconciling public demands and needs with available resources.

Our starting point is to reinforce the existing strengths of our health care system and maintain the best quality of care and the highest ethical standards. After all, health care is for people, not vice versa.



It is important to involve people in the process of advances in health care. Cooperation and collaboration among health professionals, and then among the various social services disciplines is vital to any hope of success. But it is the people we serve - however indirectly - who must themselves be involved. It is the "client" of health care services who must be instrumental not only in the maintenance of the individual's health but in helping to plan and implement health services in the community.

Health care is never long out of the spotlight of public attention and debate.

As a health policy maker, I am keenly aware that government and the health care system are responsible to the citizens that support them. In times of fiscal restraint, the decisions we make on resource allocation in health care are really statements of public value. They must be made in consultation and cooperation with the people.

In the words of C.E.A. Winslow, the leading theoretician of the American public health movement during the entire first half of the twentieth century - "the program is far sounder





if worked out in honest and open discussion, in which the experts and the public participate, than if it is prepared by the expert alone in his ivory tower".

As a politician and decision-maker, I know that innovation is necessary and yet delicate. Policy makers have an obligation to pursue necessary change, but to do so in a way that is sensitive to the basic attachment people have to quality health care.

We must demonstrate a commitment to an orderly transition from the old to the new. And we have an obligation to demonstrate the success of new ideas. In Canada, this burden falls largely to my provincial counterparts, because they are in the front lines of service delivery.

Together, we are prepared to share ideas and the results of experiments; to be supportive of innovation and to adopt what works in other jurisdictions, that may be workable in our own.



I believe that Canada has an excellent chance to continue to pioneer the health care delivery system that will take us into the next century. Our system is not in need of reform; it is not too expensive and costs are not out of control. It does, however, require adjustments in the areas of maximizing its cost-effectiveness and shifting to a more community-based approach to meet emerging and future challenges.

We will do that by preserving the best of the old and adopting the most promising of the new. I like to think that such a pragmatic blend of common sense and vision is typically Canadian.

I invite health policy advocates and decision-makers in the United States to learn more about our health care system. You will find us eager to share our experience.



# speech / discours

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*Speaking notes for*

*The Honourable Perrin Beatty, P.C., M.P.*

*Minister of National Health and Welfare*

*1989-90 Annual Meeting  
Canadian Association of Pediatric Hospitals*

*October 3rd, 1990  
Delta Hotel, Montreal*



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I want to begin by saying what an honour it is for me to be here at this important annual meeting of the Canadian Association of Pediatric Hospitals, a meeting at which your association will be examining issues which may have a profound impact on the directions you take in the future.

I want also to congratulate each of you here today for your abiding commitment to the health of Canadian children, a commitment lived out every day in the emergency rooms, operating theatres and wards of your hospitals.

Pediatric hospitals in this country have an impressive record of recognizing the special needs of children and in caring for them when they are sick. In 1875 the Hospital for Sick Children in Toronto was opened, becoming the first children's hospital in the country. It was a charity hospital, established to serve poor, sick children who were destitute and friendless, whose parents were unable to care for them and who could not receive attention at home.



The first three patients at the children's hospital were Maggie, scalded with boiling water; Albert, with a complication of diseases and "altogether a sad, sick little fellow"; and Alice, hideously burned in an accident with a coal-oil lamp. I note with interest that two out of the three first patients of our first children's hospital were suffering the effects of accidental injury.

Today there are ten pediatric hospitals in Canada, and six others with affiliated pediatric departments, meeting many of the same needs of children that were met by that first hospital a century ago.

I have two children. When my eldest, Christopher, was two years old, he also suffered a terrible accident, or to express it more accurately, a "preventable injury", getting into the bath, alone -- for both my wife Julie and I each assumed he was being watched by the other -- Christopher turned on the hot water and scalded himself severely on his legs and feet. We took him immediately to the Children's Hospital of Eastern Ontario, where he was treated quickly, expertly, and with great care. We, like so many Canadian parents, were deeply grateful to be living within reach of such a resource.



Hundreds of thousands of children benefit each year from the services provided by the member hospitals of your organization and, historically, those hospitals have been on the leading edge of change. You have recognized and advocated that children must be viewed not merely as medical cases with physical ailments but as human beings whose health is dependant upon social, economic, mental and physical factors.

You have further recognized early on that the vast majority of patients you treat have families. The provisions made in your hospitals for the involvement, comfort, and even accommodation of family members in the treatment of the children you serve are in themselves a small revolution in health care.

Your member hospitals have also led the way for change in services for children outside your own facilities. Outreach programs, and the extension of family-centered programs to children's units in general hospitals are evidence of your sincere concern with the health of children everywhere.





Today, you have gathered to talk about change. Those of us who care for children in Canada must focus on change, for the health issues facing children in our country are indeed changing dramatically.

Some of the changes are good. In the past thirty five years, for instance, we have seen a marked drop in the infant mortality rate in Canada from 41.5 per 1000 live births in 1950 to 7.3 in 1988 -- a decrease of over 80 percent!

Today, most Canadian children are born healthy. Their parents are assisted from the earliest stages of pregnancy by a network of health, educational, and support services offered through the medical community, voluntary health associations and government agencies.



But why do even a small percentage of our babies die before their first birthdays? The most significant reason lies in the problem of low birthweight. In Canada, over the past ten years, we have witnessed a constant average of 6 percent of infants born on or below 2500 grams, the minimum healthy birthweight set out by the World Health Organization. Low birthweights contribute to 75 percent of all early infant deaths, and while we have developed sophisticated technologies for improving survival of low weight babies, the rate of low birthweight remains virtually unchanged.

This fact raises the important question of cause. It is increasingly evident that environmental, social and economic factors are major contributors to low birthweight, and overcoming these factors will have to be the focus of health promotion strategies in the future if the situation is to improve.



Illness patterns in Canadian children have also changed over the last 50 years. Although infection is still a leading cause of illness in our children, they are now less likely to die from these infections than before. The improvement in the control of communicable diseases among children can be attributed in large part to the expansive immunization programs that we have established in Canada, and to our efforts to monitor and prevent immunizable diseases.

There are, however, persistent threats to the health of children against which no vaccine has been developed. Diseases of the respiratory system, including asthma and upper respiratory infections are now the leading cause of hospitalization in children. For many of these ailments, there is no effective prevention and only symptomatic therapy. Once again, environmental, social and economic factors are increasingly known to influence these conditions.





There are also ailments for which no vaccine will ever be developed. Suicide is one. The mental and social well-being of children has as marked an impact on their lives as has their physical health. Children change rapidly as they make the transition from childhood to adulthood; most adapt successfully as they move from one stage to the next. Others cannot bear the pain and end their lives. Suicide, accounting for 15 percent of all Canadian adolescents deaths, is now the second leading cause of death in the age group of 15 to 19.

This past year, the Canadian Institute of Child Health, with assistance from a number of your member hospitals, published a report called *The Health of Canada's Children*. The document is a major accomplishment, spelling out important challenges before us all.



This document confirms a statistic that shocks many Canadians -- that preventable injuries are the leading cause of death for Canadian children between the ages of five and fourteen.

More than half of all the deaths among children in this age group are directly related to injury. The causes and nature of these injuries tend to vary with the age of the child. In younger school-age children, most injuries and deaths occur as a result of traffic accidents where victims are pedestrians. Among children aged 10 to 14 years, traffic accidents involving children on bicycles result in the greatest number of fatalities.

The statistics from native populations present the most disturbing profile. Although declining, the death rate from injuries among status Indian children is consistently higher than the national average.



The rate of preventable injury in this country could well be called an epidemic, for the situation faced by our children conforms to every classic definition of epidemic; the condition is rampant throughout a known geographic area, it is widely diffused and is rapidly spreading. I choose to use the word epidemic because I believe that part of the problem in arresting the rate of injury in this country lies in a vocabulary which is misleading.

Because we refer to these injuries as accidents, we tend to look upon them as both unintended and unavoidable. No-one disputes that they are unintended. Many of them, however, are clearly avoidable.

It is not unavoidable when a child is knocked off her bicycle by a driver speeding through a well-marked school zone, or a little boy is burned to death in a house where a kerosene lamp has been left burning all night.

It is not unavoidable when a toddler placed in a walker rolls down a set of basement stairs onto a cement floor, or a four-year old opens an unlocked medicine chest and downs a bottle of staledated medicine.





Neither is it an accident when a child is knocked dead by the side of a road by a drunk driver. But it happens all too frequently.

There is, of course, an ongoing temptation to see each incident and injury as an unpredictable, unavoidable twist of fate or act of God. But we must not. The word injury itself stems from the Latin not right. We must learn to look at accidents just that way - as aberrations, matters that should, indeed, be under our control, as preventable as tuberculosis. If they are allowed to occur, then we have served our children poorly.

We must join together on this issue -- governments, hospitals, child service groups, volunteer organizations and sports associations. Information about the causes of injury must be everyone's concern because ignorance is a killer, and it's killing more of our children now than anything else.

As it has become evident that injuries account for such a great deal of suffering and loss of life, it has become correspondingly important to have reliable data on what injuries occur, how they happen, and to what extent they are preventable.



To collect this data, my department recently established the Children's Hospitals Injury, Research and Prevention Program. Known by its happy acronym CHIRPP, this program is a surveillance system used to collect information on injuries from across the nation, beginning with the pediatric hospitals in your association. The program has been up and running for half a year now, and is working well. Co-ordinated by the Laboratory Centre for Disease Control in the Health Protection Branch of my department, CHIRPP is closely patterned on the Australian national injury surveillance program.

Your association has been instrumental in establishing CHIRPP, as have others, and I believe this initiative is a fine example of the sort of leadership and collaborative partnerships between groups that make the sharing of expertise and experience viable in health protection and promotion.



Your ten hospitals formed the original foundation of this program and your cooperation has been excellent. Seeking to broaden our information base, we have recently added two large general hospitals to the program, l'Hôpital de L'Enfant-Jésus in Quebec City and the Stanton Hospital in Yellowknife. The addition of the Stanton Hospital will help provide rural and native population coverage, serving as a collection point for information on injuries in the Northwest Territories.

My department and I are committed to this program and are looking to enhance it. In the future, we will continue to expand CHIRPP in economical ways to include hospitals in other regions and in other social and economic situations, so that our expanded program may provide a national perspective of the injury problem as it affects urban, rural, Native and non-Native populations.

I would like to share with you now some of the highlights of the first wave of CHIRPP information. The data coming in have already given us a good indication of the size of the problem -- the burden of injury on children, families, health care institutions and communities.





In the first nine months of operation, the program has collected some 20,000 reports on children's visits to emergency rooms. Of these, well over half required treatment of some kind. Five percent were actually admitted to hospital. Forty percent of the injuries involved children 5 or under, thirty percent aged 5-9, and just under thirty percent 10-14. The locations of injury were as follows: nine percent on public roads, seven percent in public playgrounds, seventeen percent in schools, and forty-five percent at or near home.

Data such as these begin to paint an accurate picture of the causes and circumstances under which accidents occur. Our challenge now is to put that information to use in planning health promotion strategies.

Effective prevention programs, designed with CHIRPP data in mind, will reduce the high costs of injuries estimated to total about \$700 million annually in Canada.

More important than the savings to health care costs, however, these programs -- based as they are on fact and not speculation -- will be able to reduce the tragic results of accidental injury, results which range from disfigurement and lifelong disability to child death.



Child health is fast becoming a major priority, not just in Canada but also throughout the world. There are complex and changing health problems which face the world's children, problems I learned about in some detail just this past weekend at the World Summit for Children in New York.

The Summit was an important event for Canada in many ways. Our involvement, as you know, took a high profile. We were the first country to pledge financial support of the summit almost two years ago, and our own Prime Minister co-chaired the event. We promoted the objectives of the Summit internationally, and the Prime Minister worked personally to encourage high-level attendance, particularly among leaders of the G-7 nations.

Our goals were straightforward: that the Summit focus world attention on the specific and urgent needs of children; and that nations be prompted by the Summit to work with renewed determination towards the goal of ensuring the survival, protection, and development of children in all nations.



A particular goal for Canada was that nations would be encouraged at the Summit to sign and ratify the United Nations Convention on the Rights of the Child, the first universal and binding set of standards on children's rights ever written. Our Prime Minister signed that convention on behalf of all Canadians last May, and an accelerated process of reviewing federal and provincial laws to ensure they conform to its provisions is now underway.

Was the summit a success? Sun Yat-Sen, when asked in 1920 if the French revolution of 1789 had been a success replied "It's too early to tell."

The summit is just over. But it is clear from both the overwhelming international participation and the extensive media attention given to the event that the issues faced by children are now clearly on the world's political and social agendas.





Documents stressing the urgency of the situation faced by children globally and the requirement for practicality in every measure taken to improve their situation are now in circulation around the globe. More than 70 world leaders came to New York to commit their nations to addressing the concerns of children, in the largest ever gathering of heads of state and government. These are certainly signs of success.

Another sign of success was the widespread involvement in planning for the Summit -- including groups that went well beyond government officials and diplomats. The coalition that enabled us to articulate the Canadian reality at the Summit was originally established to monitor the signing and ratification of the Convention on the Rights of the Child in Canada. Since then, the Coalition of over 20 Canadian non-governmental organizations has been able to apply its formidable energies to act as a collective advocate for children and to monitor the role Canada plays vis-a-vis its own children and those abroad. Before the Summit, to foster public awareness of the need for special measures to improve the lives of our children, Coalition members organized talks, workshops, and candlelight vigils in major cities across Canada, co-ordinated with similar events held around the world.



Coalition members met with the Prime Minister before the Summit in preparation, and the Coalition Chairperson, Mrs. Landon Pearson served as a member of Canada's delegation along with Miss Sahira Piracha, a young person chosen by the Coalition. I look forward to continuing to work with the Coalition in the coming months.

The Summit, of course, is only a starting point. Governments that signed the Summit Declaration will submit a Plan of Action stating what they will be undertaking to meet the specific needs of their own children and contribute to the greater security and welfare of children around the world.



In Canada, the Prime Minister took the first step this Monday when he asked me as Minister of Health and Welfare to bring forward to Cabinet recommendations for follow-up on the Action Plan. The Prime Minister asked that I establish in Health and Welfare Canada a new mechanism for co-ordination across government on children's issues -- to be called the Children's Bureau. A focal point for children's issues such as this had been advocated widely by groups active in the field. Many of you helped develop this concept through your contribution to the recent Canadian Institute of Child Health report, The Health of Canada's Children, which made a similar recommendation.

Furthermore, we will seek the provinces' consent so that the Convention on the Rights of the Child can be ratified before the end of 1991.

What are among the issues that I will be examining in developing the government's response to the Summit Action Plan?

Wherever I go, groups I meet express a wish that programs for children begin by dealing with those at risk -- risk of malnutrition, of exploitation, of sexual or physical abuse, of falling prey to drug abuse.





Rix Rogers, my Special Adviser on Child Sexual Abuse, recently completed a report entitled "Reaching For Solutions". His report, based on extensive consultations, states that child sexual abuse is a reality which affects children of all regions, races, religions and socio-economic classes of Canadian society. The findings are detailed and shocking, and the report makes a wide variety of innovative recommendations including the establishment of a Children's Bureau. I am personally excited by a number of Mr. Rogers's recommendations, and look forward to working in partnership with concerned individuals and organizations to help eradicate the problem of child sexual abuse.



The association between poverty and health problems is well known. Although there has been substantial improvement since 1984, in 1988 there were still 875,000 children, or one child in six, living in low-income families. The statistic is disturbing, not simply because so many kids lack the comforts and necessities they deserve, but also because the risk of developmental difficulties, such as prematurity and low birthweight, death during infancy, growth abnormalities, low self-esteem, and behavioural disturbances are increased under low-income conditions. In a country such as our own, with our resources and our values, this is an unbearable shame.

We must look sharply at the causes of poverty -- illiteracy, disability, lack of education, family breakup -- and break the cycle that keeps Canadians from self-sufficiency and on welfare. The federal government will be looking for ways to address the root causes of poverty and to work with provincial governments and voluntary organizations for effective ways of helping children escape the welfare trap.



To successfully deal with the issues which confront our children, whether poverty or low birth weight or an epidemic of injury, we in the health community must shift our focus from one which is predominantly curative to one which confronts the physical, social and economic environments in which these problems exist. Our government also must take initiatives within an overall social policy agenda which has the welfare of children as a high and increasing priority. In fact, a number of significant initiatives springing from this agenda are in planning stage now.

One important development relates to child care. The Prime Minister is on record that the national child care program will be in place and implemented by the end of this mandate. In our design of that program, quality, availability and affordability of child care will be central goals. We will be looking to expand partnerships with employers, provinces, voluntary organizations, and the community to create a child care environment in this country in which the maximum possible number of children can receive the finest care while their parents have the freedom to work.





But each initiative, even such a sweeping one as a national child care program, can only have true impact in the context of a greater national effort on the part of all Canadians to improve the lives of our children.

It will be the collaborative effort of all participants in health, not the single action of one or the other, that will make health promotion a true success.

This is where hospitals such as your own play a critical role. You are already a major link in the health chain; the services you provide are among the finest in the world, and your commitment is unquestioned. But the problems our children face have their origins in conditions and attitudes which need to be changed, and we will need your help to do that.



Now, with me, you recognize that the most pressing problems for children in our country are utterly preventable, but it won't be through any miracle drug that these problems will be brought to an end. The issues of injury, low birthweight and poverty must be addressed in a broader context. I urge you now to move out from your hospitals and work with us to find new ways to motivate and mobilize Canadians to better care for our children by applying the most fundamental principals of common sense, watchfulness, and responsible caring.

For it will only be when all of us -- the governments and the hospitals and the clinics and the community groups and the families and the individuals -- have determined to make a change that such a change will occur. Then we in Canada will be able to look at the quality of our lives and the nature of our society, and affirm that we are indeed a caring, healthy nation.



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Speaking Notes for  
The Honourable Perrin Beatty, P.C., M.P.  
Minister of National Health and Welfare, Canada

## The National Strategy on AIDS Revisited

National Conference on AIDS  
Vancouver, British Columbia

April 14, 1991



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In 1989, a Quebec City group called MIELS tried to establish a transition home for people experiencing trauma from a recent AIDS or HIV-positive diagnosis. The need was great, the solution eminently reasonable, and the funding somehow scraped together.

The community, however, was shocked by the plan and MIELS' efforts were blocked by a 2,000-name petition signed by hostile neighbours. MIELS had two choices. The first was to give up, but, faced with the critical need of their client group, they refused to do so. The second was to radically alter their strategy and seek the support of the community, instead of trying to bypass it.

The second time around they worked with civic and provincial officials. They solicited, and received, moral support from the local Diocesan Council. They obtained financial support from a community of nuns and a private foundation. They put together a public information campaign designed to dispel the fears caused by unfamiliarity.

This time, the housing project got the green light and, as an unexpected bonus, three of the local nuns signed up as full-time volunteers.

Working in isolation, the group failed. As soon as they understood and developed their partnerships, they succeeded.

The success of this conference is utterly dependent upon that principle. The issues facing frontline workers are impressive in variety: from caring for people who are ill, to fighting for their human rights, to educating others to avoid the disease. They simply cannot be solved by any one group working in isolation from others.

Similarly, the theme of partnership is integral to the National Strategy on AIDS. If you examine it closely, you will see that our most ambitious projects are those where we can call on the resources of more than one organization.

One example is our knowledge, attitudes and behaviour study of men who have sex with men.

With the help of volunteers from the community, the organizational skills and knowledge of the Canadian AIDS Society, the scientific expertise of the universities of Laval and Toronto, and funding from my department, this project will enable us to access gay men in 29 communities across Canada. The information we gather will be invaluable in helping us persuade people to change risky behaviour.

The AIDS in the Workplace initiative which I introduced to the Toronto business community last month is utterly dependent upon partnerships.

Fewer than 5 percent of Canadian corporations have an AIDS in the workplace policy. And yet, by the end of next year, AIDS could well be the leading cause of death in Canada for men between the ages of 22 and 44.

The Canadian AIDS Society, with the financial support of Health and Welfare Canada, the Life and Health Insurance Companies of Canada and seven major Canadian corporations, was able to develop an excellent package, designed to help business implement an effective AIDS in the workplace policy.

So far, the response has been excellent, and the CAS has received hundreds of requests for information from businesses across Canada.

The synergistic power of partnership has enabled us to make significant progress since I announced our National Strategy last summer.

Since June of 1990, my department has committed \$34 million to the National AIDS Strategy, supporting more than 80 community organizations and hundreds of projects across Canada. Fourteen million dollars has gone to bio-medical initiatives and research, seven million to education and prevention and another four million to care and support.

I don't want to read you a list of all the projects we have funded (that would take a lot longer than the 20 minutes I have been allotted) but I would like to describe a few which I think show particular merit.

On the biomedical side, the Federal Centre for AIDS has produced a new HIV test which allows us to detect the presence of the virus from a single drop of blood on filter paper. The advantage is that dried filter papers can be shipped without stringent temperature control and can be stored indefinitely. I am proud that Canada has developed a technology particularly valuable to Third World countries.

On the social side, we are searching for ways to strengthen community services. Many people living with AIDS don't want to be institutionalized, nor can governments afford to misuse scarce resources. Given the choice, most PWAs will ask to live and die in their own homes. Unfortunately, few communities can provide the support they need.



Consequently, we are developing two pilot projects with provincial governments, one in Alberta and one in Quebec, to provide integrated community care for people living with AIDS in their own homes. At the same time, through the National Welfare Grants, we are funding a national study of housing to develop alternatives for people living with AIDS, as well as a pilot study exploring the use of home services.

On the research side, we have seen similar progress. As you know, our ability to fight HIV and AIDS, in the past, has been somewhat hampered by a lack of trained Canadian researchers. That situation is slowly improving.

Since 1986, my department, through the NHRDP, has contributed more than \$30 million to AIDS research, with funds earmarked to train new researchers and provide salary support for career researchers working in the field of AIDS. A few years ago, we supported a handful of researchers. Today, that number is more than 100.

Working in partnership has enabled us to target our resources more effectively and reach a wider audience.

For example, it is probably self-evident to say that any program designed for aboriginal people must be based on aboriginal beliefs and values, but prior to now we have not been effective at doing so.

Our knowledge, attitude and behaviour studies, supported by the Chiefs of Ontario and by the Swampee Cree Tribal Council, promise to help us develop programs sensitive to the cultures of aboriginal people.

Similarly, we are funding the Canadian Ethnocultural Council, an organization representing more than 2,000 local chapters across Canada, to develop a national action plan for AIDS in ethnocultural communities.

We believe that the involvement of the community is essential, and that is why the AIDS Community Action Program was enhanced by almost 50% when I announced the AIDS Strategy. ACAP now provides funding to more than 75 community-based AIDS groups.

These are a few of the areas where we have made significant progress. However, some of our projects have been more complex to implement. One of them has been TISAH.

When we announced the project last summer, I was very optimistic. A treatment information system for HIV was a new idea, one that has been developed by the community and is unparalleled throughout the world.



Its intent is to provide information to doctors, community groups, and people infected with the virus alike, about a whole range of new treatments, be they holistic or traditional.

As you all know, TISAH has had problems in completing its design phase. A couple of weeks ago, the University of Toronto prepared a business plan which outlined the work that has been done so far, as well as the considerable amount of work which still needs to be done to develop the system.

From its inception, TISAH has been guided by an advisory committee made up of members of the AIDS community representing the Canadian AIDS Society, the Canadian Hemophilia Society, AIDS Action Now!, the Canadian Public Health Association, and others. Following the report from U. of T., committee members have concluded that we should examine other options for a new location for the system. I have accepted their recommendation.

I remain committed to the concept and development of a treatment information system for AIDS and HIV. TISAH will be done, and it will be done right.

We have put together a transition team made up of a representative from my department, from the community groups and from the University of Toronto. Their job will be to determine the work which still needs to be done, and to drive the selection process to find a new home for TISAH.

They will be reporting to me regularly and will liaise with all of the stakeholders in this important project. An important function of this transition team will be determining what work can be resumed immediately.

I have been very pleased with the collaborative nature of our partnerships on TISAH, particularly as they relate to recent difficulties. It is because of this collaboration that I remain convinced we can bring this project to fruition.

Another area which I know has challenged many of you here tonight is AIDS in prisons.

Last year, I announced that Dr. Catherine Hankins would be conducting a feasibility study on seroprevalence in prisons. I am pleased to report that she has completed her work and has developed four options for Corrections Canada which would allow them to develop a better picture of HIV in the prison population.

Officials from my department and Corrections Canada are meeting, on an ongoing basis, and I am satisfied that progress is being made.

A third area of concern has been the treatment of short-term visitors to Canada who have AIDS. Last summer our Expert Advisory Committee concluded that AIDS and HIV are not a threat to public health during short term travel to Canada.

My officials provided this advice to Employment and Immigration as input to the Medical Inadmissibility Review Committee, who are reviewing this question as part of a larger assessment of immigration medical issues.

I am pleased to announce that we have revised the guidelines for our medical officers involved in immigration medical assessments, and with the cooperation of my colleague, Barbara Macdougall, we will ensure that visitors with AIDS or HIV infection will be treated in exactly the same manner as any other visitor to Canada.

In each of these instances - with TISAH, with the prison system, and with immigration - our success in the past and our success in the future will be measured by how well we work in partnership with other departments and organizations.

A very major player, in this respect, will be the provinces and territories who must develop their own plans within the framework of the National AIDS Strategy.

I am pleased to see they have started to do so. New Brunswick has already published its strategy for education and prevention. Ontario has indicated that it is starting to develop its plan, and I am delighted to hear that the Minister of Health for British Columbia will be addressing you tomorrow on the nature of this province's efforts.

I am also pleased to report that we have reached a formal agreement with British Columbia to jointly conduct a seroprevalence study. The study will begin this month and will test more than 9,000 unlinked blood specimens, giving us a much better picture of HIV in this province. This agreement is the first of a series to be signed with other provinces.

I know that a call for partnership is sometimes used by people as an excuse to avoid responsibility. I also know that partnerships are not easy to develop. Different groups may have differing values and conflicting theories of which approach is best.

The example of MIELS which I recounted at the beginning shows, however, that effective partnerships can accomplish tasks individuals simply cannot. In that respect, AIDS has taught us a valuable lesson.



Each disease we tackle as a society has lessons to teach us about how we provide health care, conduct research and treat those who have the misfortune to contract it. AIDS, however, has taught us more than any other, because of the way the disease and the treatment of it have developed.

- For example, AIDS has changed the relationship between doctor and patient.

People living with AIDS are extremely well informed and involved in their own health care. Community networks have been developed to support them. Doctors dealing with AIDS are required to devote significant time to learn about new therapies and techniques and are faced with questions and demands from patients who, in some cases, are better informed.

- AIDS has challenged basic assumptions about how research should be conducted.

Can you name any other disease where a full-scale public debate has ensued over the merits of anonymous testing? Or where the value of bio-medical research as opposed to psycho-social research has been seriously challenged? A plethora of ethical questions has been raised and new guidelines have had to be developed for AIDS research.

- AIDS has shown us that the solution to the disease must come from those most affected.

Any effective partnership demands that people from the community be involved in policy forums. That is why I have made it a point to include people living with AIDS in our clinical trials network, on NAC-AIDS and the Expert Advisory Committee.

- AIDS has taught us about discrimination.

Everyone in this room has seen discrimination first-hand. An early study by the B.C. Civil Liberties Association listed many examples, including one from an Ottawa AIDS group who were told they could lease space only if they promised to build a separate washroom.

Another came from an HIV positive male whose welfare worker refused to visit his home, saying she might catch AIDS from his cats.

A third concerned a landlord who refused to rent an apartment to a woman, whose husband had died from AIDS, even when she showed she had tested negative for the virus.

- Finally, AIDS has taught us more than we ever wanted to know about grief.



My first experience with the disease came long before I joined the department of Health and Welfare. I watched two people whom I knew and respected, experience the pain, frustration and grief which accompany HIV. They are both dead now.

Since then I have met with many people living with AIDS or HIV, including Paul Maingot, Doug Bonnell and Alex Kowalski. I understand the feelings of grief many of you feel at their passing but let me assure you their courage was admired and their voices have been heard.

They taught us to challenge our value systems: the way we care for people, how we educate them and how we conduct research.

Their experiences taught us to be sensitive to the differing needs of a diverse society.

They showed us the need to treat people living with AIDS with mutual respect and dignity.

Because of them, AIDS has become the model for dealing with disease and people forced to live with it, in the 1990s.

Even so, there remains a great deal to be done if we are to cure the disease and care for those who acquire it.

Where do we go from here?

Let me deal first with the question of money. I know that you are aware of the need for the federal government to put its economic house in order. That means constraining all levels of spending, including grants and contributions.

This will require setting priorities and, in the case of my department, we have decided that AIDS will continue to be our highest priority. The ACAP program which provides funding for community groups fighting AIDS will not be affected by the difficult decisions we have to face.

Several groups have also approached me with questions about future funding for the National AIDS Strategy.

As you already know, I have Cabinet approval for a five year program which ends next year. Obviously, AIDS will not disappear when current funding is scheduled to run out and I am committed to returning to Cabinet to request funds to continue our fight against AIDS.

Unfortunately, we still don't know precisely how many Canadians are infected with HIV. Our first challenge therefore, is to develop a national program on seroprevalence, building a mosaic of information from the results of the anonymous, unlinked testing and voluntary testing methods.

Our second challenge will be to develop more sophisticated methods of treatment.

In the early 1980s, we tried to help people with AIDS die with dignity. By the end of the 80s, we began to see how PWAs could live productively with AIDS. Our challenge now is to improve the overall quality of life of people living with AIDS.

We will take a holistic approach, recognizing that the social and community needs of people with AIDS are as important as the medical ones. Together, we will examine models and options for "accelerated" or "optimal care."

Our third challenge will be to coordinate our efforts in education and prevention even more.

There are so many active players and so many different voices that sorting out roles and avoiding costly duplication must be a priority in gaining new ground against the epidemic.

We have made a great deal of progress in a short time. We have supported community groups and scientific research. We have seen provinces come forward to join in the strategy and are hopeful that more will come forward in the future. We have pilot programs which are models of community care. Most importantly, we have come to understand the fundamental requirement for partnership.

In the past 100 years, the world has become far too complicated for single individuals to make huge amounts of difference. Our scientific advances are now, virtually always, the result of incredible teamwork, conducted across national boundaries and throughout the world.

This is indisputably true in the world of health and medicine. AIDS is not just a complicated medical issue beyond our current understanding, but it is also a social ill with elements that reach into every facet of life.

We must gather together, as professionals and as ordinary Canadians, pooling our expertise and our material resources, but also our hope and our faith that through this partnership we can achieve a single clear objective in the 90s: the utter defeat of AIDS.

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NOTES FOR AN ADDRESS  
BY THE HONOURABLE BENOÎT BOUCHARD  
MINISTER OF NATIONAL HEALTH AND WELFARE



THE 124TH ANNUAL GENERAL MEETING  
OF THE CANADIAN MEDICAL ASSOCIATION  
TORONTO, AUGUST 12, 1991

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Canada





Mr. Speaker,  
Mr. President,  
Delegates and Observers,  
Honoured Guests,

I am very pleased to accept your invitation to speak to you today.

In its capacity as a body representing the entire medical profession, the CMA plays a truly vital role in Canada, not only in the health area per se, but also in all issues relating to social policy in general.

This 124th annual meeting of the Canadian Medical Association again promises to generate worthwhile discussions. I note that the impact of the new technology on practice and its financial impact, as well as the equitable distribution of human medical resources will be on your agenda. I shall be greatly interested in examining the conclusions you reach in your workshops.

Since the Prime Minister invited me to take on the responsibility of Minister of National Health and Welfare, a little over three months ago now, I have had the opportunity of meeting a number of Canadians from coast to coast.

In these meetings I have noted a great deal of satisfaction with our health system, but also a great deal of concern about its future.

This is the sixth department that has been entrusted to me since my arrival in Ottawa in 1984, and in each of my mandates I have had an opportunity to meet with numerous individuals and groups to discuss their concerns. But never before today have I had the opportunity to speak with people with such strong convictions and desires concerning as specific an issue as the future of our health system.

Nevertheless, in a context of increasing limited governmental financial resources and escalating health service costs, many Canadians are wondering about the ability of governments and the various bodies involved in the health field to provide in future a quality of care, if not superior, at least equal to what they have known for more than twenty years now.

One thing is certain, however: Canadians' fervent wish to see the key principles underlying our health system, which are an integral part of the Canada Health Act, continue to exist. As well, they are coming to recognize that maintenance of these key principles will require, from both governments and those in the health field, a clear desire to deal with the problems facing our system, and, more particularly, the necessary boldness to solve those problems.

In this context, it is clear that Canadians are calling upon us - both us in government and you who represent one of the most influential groups in the health field - to find the most appropriate solutions to the problems facing our health system.

This is why I would like to discuss two issues with you today: on the one hand, the challenges we must face in the medium and long term in the health field, and on the other, the role the federal government could - or should - play so that we may face up to these same challenges.

But before addressing these issues, let me first of all call to mind briefly that in the Fifties and Sixties, Canadians chose, through their governments, to invest considerable resources in the creation of public health systems based on universality and accessibility. This choice was justified by the fact that health is not only an essential component of personal well-being, but also an essential condition on the collective level for the economic prosperity of our nation.

Today, there is no doubt that health still plays an equally essential role both individually and collectively. Given that the reasons which at the time justified creation of the health care system as we know it today are as valid and current as ever, Canadians will continue to insist that no changes whatsoever be made in future to the foundations of this system.

Nevertheless, our health system is required to evolve, and probably to undergo transformations, because the challenges it is faced with are real ones and that a refusal to respond properly to them would, before long, lead to a breakdown in the quality of care and possibly an erosion in the principles of universality and accessibility.

We are very familiar with these challenges. They have been identified by a number of commissions of inquiry, parliamentary committees, or working groups that have been set up since the early Eighties by the provinces, the federal government, or professional associations such as the Canadian Medical Association.

They are first, of all, connected to the demographic changes which characterize the Canadian population and will continue to characterize it in years to come.

As well, they are connected to the new medical technologies, the development and use of new drugs, the distribution of human resources and the organization of health networks - as well as, finally, the expectations of the population.

The common point of all these factors is that they result in constantly rising costs for health services in all regions of Canada.

From 1979 to 1988, health expenditures in Canada rose an average of 11% annually. At the present time, health-related expenditures total some 60 billion dollars yearly, 43 billion or so of this sum coming directly from the various governments.

At this time, Canada is devoting 9% of its gross national product to health expenditures. We are the second-ranking country in the world, after the United States, in health expenditures.

Pressures on provincial health systems because of these rising costs are such that the provinces are now devoting close to a third of their budgets to health.

For its part, the federal government is this year devoting more than 16 billion dollars to funding provincial health systems through transfer payments under established program financing arrangements.

It is worthy of note, in this connection, that federal transfer payments to the provinces have doubled in the past ten years.

It would be a delusion to believe that governments, both federal and provincial, will be in a position to allocate substantial new financial resources to cope with this dizzying increase in costs; Canadians are well aware of this.

If we wish our health system to continue to be based on the principles of universality and accessibility, we have no other choice but to ensure that health costs remain affordable. To do so, we must be able to count on the participation of all parties involved in seeking and implementing solutions.

I do not pretend to have all the answers to the challenges faced by our health system.

While recognizing the jurisdiction of the provinces in the health care field, the federal government feels that it still has a role to play in this area.

If there is one responsibility which lies with the federal government, it is to safeguard the key principles set out in the Canada Health Act: universality, accessibility, portability, comprehensivity and public administration.



In this connection, the federal government is still as determined as ever to ensure maintenance of these principles in their entirety within the provincial health systems. The tabling of Bill C-20 in the House of Commons is clear evidence of this determination.

Realistically, the role of the government cannot be limited to acting as the guardian of the key principles of our health insurance system.

It is urgent for us to collaborate with the provinces and territories to help them solve the problems being faced by the provincial health systems.

It is precisely for the purpose of meeting that responsibility that we have recently created, in conjunction with the provinces, the Canadian Coordinating Office on Health Technology Assessment as well as undertaken research into the human resource situation.

On another front, the federal government will continue to play a lead public health role by continuing its campaigns against AIDS, smoking and drug and alcohol abuse.

It is an obvious prerequisite in the search for solutions in the health field to have a sustained dialogue between the various parties involved, be they governments, health professionals or health service consumers.

In this connection, I must point out the positive atmosphere and the feeling of partnership which was felt during my meeting in June with my provincial and territorial counterparts.

Laying the groundwork for an ongoing dialogue on possible approaches to an improved health system remains, in my opinion, an essential condition for developing a health policy for the Nineties.

In fact, all the stakeholders in Canada's health care system must collaborate in the search for greater efficiency in an ever-improving system. For this reason, I am especially pleased to note that the Canadian Medical Association has withdrawn its legal challenge to certain provisions of the Canada Health Act.

Indeed, there are many issues on which health professionals and governments agree. There are issues on which our differences will challenge us. But this is a time for dialogue, for conciliation and for collaboration.

In this respect, I welcome the informed contributions of the Canadian Medical Association. We have already heard from HEAL, the Health Action Lobby of which the Canadian Medical Association is a member; and I am looking forward to what I am sure will be spirited debates on how Canadians' health interests can best be served in the future.

Money is not our only problem. We need to look critically at the quality of our health care, human resource planning and problems related to environmental health and other issues. All the stakeholders can work together to find solutions. We each have unique and important perspectives to bring to bear. It is important that we all have an opportunity to be heard.

The Canadian Medical Association was an early supporter of the principle of universal health care in Canada. I thought it was interesting to see that Malcolm Taylor, writing for The Institute of Public Administration of Canada, praised the Canadian Medical Association for its foresight and cooperation in the 1940s as the system that was to become Medicare was being developed.

Taylor described the Association's contribution at that time as "...Canadian organized medicine's finest hour." I would echo that praise. I would also say that, as technology makes medicine more complicated, as the aging of our population presents new challenges to our ingenuity and as our resources remain limited while our needs and expectations increase, organized medicine will, I am sure, respond with vigour and commitment.

In closing, I would be remiss if I did not take the time to emphasize the important link that exists between Canada's health and national unity.

We are all aware that Canada is passing through a critical point in its history, a national identity crisis without precedent.

While Canadians are hard put to identify the symbols that hold us together, the existence of our health system, with its key principles applicable to every region of the country, constitutes without a doubt one of the institutions which makes the greatest contribution to Canada's distinctiveness, to its being a real country.

Like national unity, our health system remains a fragile thing to which we must give every attention, onto which we must focus a collective desire for its continued survival.

Canadians have their country at heart, their health system at heart. In the months to come, we shall see whether this desire is a real one, and if it can be translated into concrete actions.





# speech / discours

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Speaking notes for  
the Honourable Benoît Bouchard  
Minister of National Health and Welfare

International Conference  
World Federation of Therapeutic Communities  
Drugs and Society to the year 2000  
Montréal, September 23, 1991



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Health and Welfare  
Canada

Santé et Bien-être social  
Canada

Canada



Thank you for inviting me to join you at this conference. I am pleased to be here, not only to speak, but also to listen. We have much to learn from each other and so few opportunities to share our experiences.

We are all on a common journey, moving at almost lightening speed toward the twenty-first century. And looking around us, as we speed toward the future, we see rapidly changing landscapes. What is familiar today is gone tomorrow, as boundaries disappear and perspectives broaden. The problems that we think we understand change and assume alien forms. We are like still photographers trying to capture problems in motion. We study freeze-frames when what we are trying to analyze is like a motion picture, always progressing.

And so it is with the global drug problem. Traditional smoking of opium and chewing of cocoa leaves have been replaced by heroin and crack as drugs of choice for street users. The so-called designer drugs are changing so fast that by the time the ingredients are identified and the drugs designated as illegal, new - and often more powerful - variations have emerged.

This is the nature of our dilemma - To slow the development of the problem long enough to allow ourselves time to find solutions. And to become sufficiently future-oriented that we are not always looking at today's problems on yesterday's terms. In that context, I would like to talk about Canada's efforts to develop a strategy that is oriented toward the future.

Canada's drug strategy was launched in 1987 as a five-year program to respond to growing concern over our country's alcohol and drug abuse problem. By 1987 many groups and individuals, within and outside government, had come to believe that a collective effort was necessary if our country was to mount an effective campaign against substance abuse.

There was general consensus that the problem is complex -- affecting many groups and sectors of society. Multidimensional, with economic, political, social, and health implications. And growing in size.

The drugs of choice now range from social drugs such as alcohol; to street drugs such as cocaine, marijuana, and heroin; medicinal drugs such as tranquilizers and sleeping pills; anabolic steroids; and products such as glue used as inhalants.

Let me cite a few statistics.

Recent surveys show ten per cent of Canadian adults drink alcohol at levels that put themselves and others at risk.

There is a growing concern about dependence upon prescription drugs, especially by women and seniors. Canadians have the dubious distinction of being among the world's largest per capita users of tranquilizers, sedatives and narcotic analgesics.

A 1989 survey suggested that more than six per cent of adult Canadians had used marijuana in the previous year.

There has been a slight decline in the number of users of street drugs, but those who abuse drugs face increased risks. Street drugs are more potent than ever. Moreover, substances are administered through more dangerous means - by injection and smoking. Those who do use drugs are consuming them more frequently and combining drugs in ever more innovative and dangerous ways.

Some large Western centres and more isolated communities in Canada are reporting increased use of non-traditional intoxicants -- household detergents, solvents and diverted prescription drugs.

Canada has recently become a transit point for drugs en route to other countries, resulting in more and larger drug seizures by Canada customs, the Royal Canadian Mounted Police and other police forces. In 1991, Canada customs seized more cocaine than in the previous ten years combined. The Royal Canadian Mounted Police are reporting similarly large increases in the amount of cocaine, heroin and marijuana seized.

This is a thumbnail sketch of the Canadian situation. And it will probably not sound unfamiliar to you. Countries around the world have experienced the drug problem in similar ways. Yet even while sharing a common problem, each country has chosen its own solution.

Today I would like to share with you some of the features of Canada's drug strategy and the successes we've experienced to date. As I said before, the one orientation that, more than any other, has influenced the shape and content of our drug strategy is Canada's orientation toward the future.

First, it has prompted us to take a balanced approach to our drug problem.

This means that in 1987, the federal government began to take stronger action in the area of reduction of demand for drugs.

On the supply side, Canada, of course, continues to take strong actions. In 1989, we enacted Bill C-61 to enable the seizure, and subsequent forfeiture, of the proceeds of crime. We are increasing our surveillance activities at airports and other border crossings. Enhanced coastal watch programs are in place.

As Prime Minister Mulroney noted in his opening address, Canada is also contributing at an international level. Canada was an active participant in two economic summit task forces. We have acceded to three international drug conventions. And we signed formal cooperative agreements with many partner states in the United Nations' global plan of action.

We believe that, as long as there is a demand for drugs, supply will follow. If we remove one drug, people will use another. If we remove current suppliers, others will replace them. Centring strictly on supply is like cutting off food from a starving man. The need doesn't disappear, only the means of fulfilling the need.

The federal government did not always take a balanced approach. For many years, we focused predominantly on supply, leaving the demand problem to provinces and local governments. But the situation is different today. People on both the demand and law enforcement sides accept the necessity to work together to solve Canada's drug problem. And there are many cooperative efforts.

Second, our orientation toward the future has motivated us to place an emphasis on youth. Our young people are among the groups most at risk - especially school-aged children, children of alcoholics and the children from violent homes. School drop-outs and the homeless also require special attention.

We believe that education of youth is Canada's best hope for a healthy future. Thus, a large number of our programs are geared towards helping youth. The Royal Canadian Mounted Police, for example, have launched a drug awareness program that has achieved international notice for its effectiveness in reaching these and other groups.

Through this program called PACE, which stands for Police Assisting Community Education, our national police force held workshops across Canada to instruct its officers on how to deliver prevention messages to youth.

Third, Canada's future orientation has lead those involved in the drug strategy to place a stress on changing lifestyles attitudes. If we can eliminate the reasons that people take drugs, we have the best chance of success with the next generation. People are most committed to choices they make themselves. We want to help people reject drugs instead of being forced to relinquish them.



We recognize that changing attitudes and lifestyles is never easy. And it is certainly not a short-term goal. It requires a long-term commitment, a commitment made at grass-roots level and sustained by governments as well as by those most intimately involved with the problem.

Making the choice to give up drugs means having the option. Treatment and rehabilitation centres across Canada try to give people, particularly youth, that option.

Treatment clinics available to problem drug users also offer counselling services to families. Crisis hotlines give immediate help to those who require it.

Substance abuse in the workplace is another area of concern. Recent surveys estimate the extent of loss of productivity as a result of substance abuse in the workplace to be as high as 13 billion dollars.

We believe that only a comprehensive approach to the drug problem will result in success. Such an approach, we feel, must involve the families of drug users, their communities, their employers, and others with whom they are in close contact. In other words, we believe that drugs are a lifestyle issue, and solutions must be comprehensive, yet adapted to individual needs.

Fourth, our orientation toward the future is leading us to place an emphasis on the achievement of many local successes. We believe that, in the long run, success will be achieved at the local level. There are many groups that we can't reach through national programs and mass media. Advertising campaigns and public service announcements often don't reach the high risk groups such as street youths and the homeless. It takes social workers and addiction counsellors to make contact with these people.

Canada's drug strategy is reaching many of its target groups at the local level. To support these community-based efforts, the federal government has invested almost ten million dollars, over the last four years in about 550 community action programs. And we find the results encouraging.

We find communities taking ownership of their problems and solutions. For example, nearly 900 Native communities across Canada participate in addiction awareness activities. As a result of models set by Native chiefs and elders, many Native communities are becoming dry.



In May 1989, 150 youth leaders met in Halifax to discuss the role of community action programs in combatting drug abuse. Another forum held earlier this month in Regina dealt with empowering the family. These conferences promote cooperation, increase awareness, and highlight Canadian programs of excellence.

Finally, Canada's future-oriented approach to solving its drug problem also implies building on the collective and cumulative knowledge of partners in the strategy, present and future.

We believe our best chance of experiencing relatively long-term success is through forming partnerships and networks that allow the sharing of information and experiences.

By working together, we can achieve goals not possible by groups or individuals working alone.

Many now participate in this quest for solutions. Over fifty companies, for example, joined Health and Welfare Canada in sponsoring drug awareness campaigns. In one such partnership, Health and Welfare Canada joined with the Canadian Association of Chiefs of Police, the Alliance for a Drug-Free Canada and Marvel comic books to produce over three million copies of a special Spiderman comic book.

Our drug strategy stresses the importance of research. A recent national survey has yielded important baseline data to guide the development of future programs and policies. A national survey of adolescents under the age of fifteen is planned for 1992.

## Conclusion

No matter how much we accomplish, the challenge will not soon end. With future-oriented approaches, the challenge is ongoing. Success comes slowly, over time, with each new generation learning from its predecessors.

It has been said that what distinguishes humans from other animals is our "time-binding" ability -- our capacity to pass on our knowledge from one generation to the next. As a consequence of this time-binding ability, we can learn from those long since dead and speak to those not yet born. Each generation is able to begin at a new point, building on the knowledge and experiences of those who came before.

The sharing of information among partners, regions and countries enables all of us to achieve a new elevated base point for the next generation.

We have much to contribute and so much to learn from each other.

Thank you.

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Notes for a speech by  
the Honourable Benoit Bouchard  
Minister of National Health and Welfare



At the 38th General Annual Meeting of the  
Canadian Association for Community Living  
Ottawa, October 4, 1991

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Honoured guests, ladies and gentlemen:

It is a great pleasure to be with you for your 38th Annual General Meeting. In the years since your association was formed, you have helped change attitudes toward people with disabilities -- and changed them for the better. Once isolated from the world, persons with disabilities now have much more opportunity to live according to their own individual capacities. Society has finally begun to understand that the person with disabilities is, first and foremost, a person, with individual needs, abilities and aspirations. In deciding, in 1985, to change its name, your Association took a strong position of leadership in promoting that understanding. You are to be commended for this. But a great deal remains to be done.

We are challenged to define each person as a unique human being, and to tailor our efforts to that person's potential. This is particularly necessary where children are involved. We must create the conditions where children - all children - are valued and respected for who they are, for just being themselves. We must create the conditions where all children can feel safe and secure and rise to their full potential with the strongest possible support of their families and indeed their country.

Attempts to appropriately integrate people with disabilities are supported by a network of federal programs, some of which are implemented in cooperation with other levels of government and with community groups and organizations. Many of them depend, to a large degree, on hard-working, caring volunteers like yourselves. We often talk about partnerships and some of you may feel the term is becoming tired. But, partnerships - people working with people - is the best, if not the only way to achieve widespread attitude change.

Like you, the Government of Canada places great importance on community living. We are working with your New Brunswick Association and my colleague, the Minister of Health and Community Services, to develop Project Exodus. As many of you know, this is intended to enable persons with severe mental disabilities to move out of institutions in the province and become participants within the broader population. The Minister, the Honourable Raymond Frenette, and I recently met to review the progress made by our officials in defining a workable approach to the proposal. Our discussions are progressing and I am optimistic about the future of the project.

This project is just one part of the federal government's National Strategy for the Integration of Persons with Disabilities. It involves eleven departments and expenditures of \$158-million over the next five years. It is designed to reach three major goals: equal access, economic integration, and effective participation in the national mainstream by persons with disabilities.



Health and Welfare Canada is dedicating \$46 million to the National Strategy. Overall, the \$158 million will be used for programs that touch every aspect of the lives of those with disabilities -- from legislation to health, from transportation to housing, from access to information to access to employment. Let me tell you, briefly, about several initiatives of Health and Welfare Canada that will be of particular interest.

First of all, my Department will contribute support to pilot projects to help people with disabilities integrate into the workforce and achieve independence in the community. While funds may be used to do preliminary research and planning, the majority of the funding will be directed to develop and demonstrate new models or promoting those current models that have proven successful. We will draw on existing research and experience in community-based programs in order to develop model demonstration projects, and we will be creating new partnerships with groups that emphasize prevention of disabilities.

Secondly, we are determined that a generation of children and youth with disabilities will play the fullest possible part in our society. To assist in making that happen, we will invest \$4 million in partnerships with organizations that serve children. We will work with them to find new or better ways of integrating disabled children into their programs. Elementary social justice means offering disabled children the same level of educational, recreational and social experience now enjoyed by children without disabilities. I believe the way to realize the goal of full integration and participation of disabled individuals within Canadian society is to ensure that they grow up within an accepting and integrated environment. The integrated child will be the integrated adult.

We are doing many things to improve the lives of Canadian children. The family violence initiative, 338 projects to date, totalling \$15.4 million, addresses the serious problem of child abuse, including child sexual abuse. The daily news confirms that public awareness of such behaviour has grown. It is intolerable to all of us. Governments and agencies at all levels are vigorously responding with legal, protection and prevention efforts.

We have funded 37 projects through the Child Care Initiatives Fund on the integration of special needs children within day care services. This represents \$6.9 million dollars of support to community initiatives.

My colleague, the Minister for Fitness and Amateur Sport, the Honourable Pierre Cadieux, will mount an awareness and information program designed to help persons with disabilities become more physically active, and to make the general public sensitive to their abilities.



My Department's Medical Services Branch is consulting with colleagues in the Department of Indian Affairs and Northern Development and with representatives of the Assembly of First Nations to define strategies to improve home care services for native persons with disabilities. At the same time we are engaged in a five-year program of retrofitting, where necessary the 487 health facilities -- most in remote areas -- that are within my Department's mandate. Other projects include expanding job rehabilitation measures to help recipients of Canada Pension Plan disability benefits re-enter the labour force and a federal/provincial/territorial review of services affecting Canadians with disabilities.

A fundamental requirement of these projects is that they propose useful and practical methods to increase the participation and integration of people with disabilities. Over the next few months, we at Health and Welfare will be consulting on the National Strategy with other levels of government, and with organizations that serve children and people with disabilities, to identify the most effective methods of integration.

As a result of this government-wide initiative, I am convinced that those we love and those we serve will have a better quality of life, more opportunities to define themselves individually, and a brighter future.

Over the years, your organization and Health and Welfare Canada have worked closely together on our shared goals of improving the quality of life for Canadians. It has been a mutually beneficial relationship. I think of the collaborative effort that resulted in the film "And After Tomorrow", as well as the support for the Roeher Institute when it was researching and writing publications on vital issues that affect community living options.

I am proud of the support we gave the Association to enable it to participate in the First International Conference on Support to Families of Persons with Disabilities. I was delighted to see the most recent television commercial, undertaken with the Department's support, that is part of the important public awareness campaign on not labelling people.

No government working alone -- even if it had unlimited resources -- could meet the challenges of integrating people with disabilities into the Canadian mainstream. We value and want to build upon your ideas, your experience, and your commitment to our common goals. This is the partnership concept at its best.

The reality is that, without the pioneering work of your organization and others, we might still be frozen in the unhappy, unproductive past, when some people were consigned to lives of isolation and humiliation, on the margins of society. That changed because you cared and you made others care.

On behalf of the Government of Canada, I congratulate the Association on what it has accomplished in the past four decades. In order to assist you in your current mandate, I am pleased to announce today that we have secured \$200,000 to complete our five-year, one-million dollar commitment to support the Association's special initiative to promote alternatives to institutional care.

I urge you to continue to meet the very high standards you have always set for yourselves. Your work is essential to the task to which we are all committed - making lives of children and all Canadians, better and more fulfilling. I wish you enduring success in all your efforts.

Thank you.

# speech / discours

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**Speaking notes for  
the Honorable Benoît Bouchard,  
Minister of National Health and Welfare**

**At the National Conference  
on Childhood Injury Prevention  
of the Canadian Institute of Child Health  
Ottawa, Ontario  
Thursday, November 7, 1991**



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I appreciate the opportunity to join you here today.

First, let me congratulate the many people who have made this conference possible.

You have brought together volunteers, health care professionals, academics and policy makers in order to try to make a safer world for our children.

Because they deserve a safer world.

A child's world should be wondrous, not dangerous.

But, as you know, children sometimes live, and play in unsafe circumstances. And, too often, are in danger of losing their mobility, or their lives, to preventable injuries.

We can prevent injuries ---we can prevent the number one killer of children.

We used to think that unintentional injuries were accidents.

But as our awareness grows, we realize that we have the knowledge and the skills to prevent these events from happening.

The government of Canada, in partnership with groups like the Canadian Institute of Child Health, and with others, is committed to working toward the safety, good health, and well-being of children.

Last September, Prime Minister Mulroney demonstrated that commitment as he co-chaired the World Summit on Children at the United Nations Headquarters, in New York.

Following the Summit, on his initiative, the Children's Bureau in the Department of National Health and Welfare was created.

The Children's Bureau will foster greater public awareness and support for children's concerns. And we will make it easier for volunteers, business people, and representatives from all levels of government, to work in collaboration.

The net result will be better and more coordinated policies and programs, for issues affecting children ---issues like preventable injuries.

One of my responsibilities is to be aware of the facts that are not always pleasant. I was shocked on learning of figures that are all too familiar to you.

Every five hours a child in Canada dies of an injury. In that same five hours, 40 children are hospitalized, and 25 hundred more need attention in emergency rooms.



Canadians are proud of their success in delivering good health care to our children. Mortality rates, from all causes, are declining. But injuries still remain the number one cause of death for children over one year of age.

And Canada has one of the highest injury rates for children in the industrialized world.

We must do better.

One way to do better is to know how and why specific injuries occur ---so that we can be more effective in promoting safety and preventing injuries.

That is why Health and Welfare Canada set up the Children's Hospital Injury Research and Prevention Program.

The data collected through the Program will help us to understand the extent of, and the circumstances surrounding, injuries.

And, we hope this increased understanding will assist in preventing future injuries, and deaths. That it will lead to safer cars, safer roads, safer playgrounds, safer homes and schools, and safer practices.

While better, more detailed knowledge is necessary, we cannot let our pursuit of knowledge stand in the way of acting now.

Motor vehicles are involved in most common category of injury. And we already know that proper driver and passenger restraints significantly reduces the chances of severe injury, or death, for the passenger.

Yet, in a survey done in 1989, Transport Canada found that only 51 per cent of all children were properly secured. For children under five years old ---and this is tragic--- only over 40 per cent were properly restrained.

The challenge for all of us ---government, business, and community groups--- is to work harder to get the message out to parents, and other drivers.

Transport Canada has taken up that challenge with its National Occupant Restraint Program. The Program is aimed at increasing the number of car passengers and drivers who wear restraints properly.

The government of British Columbia has also responded. Their "Do It Up Right" campaign is working now to make riding safer.



And where a manufacturer's product, such as a car seat, is not acceptable as safe for a child, we must take effective steps to prevent the risk.

Government can take action, as under the KidsCare program of Consumer and Corporate Affairs Canada ---which Minister Blais will be discussing with you later this week.

But action must also come from elsewhere in the community.

For example, I noticed that the Institute's quarterly newsletter provides useful guidelines, and precise information, so that parents can choose a safe car seats for their infants.

This is the kind of information we need to get out to all Canadians.

Injuries are not only connected to motor vehicles. In fact, the number of fatal injuries to children in Aboriginal communities is staggering.

Native leaders, and health workers from their communities and from Health and Welfare Canada, are working to promote safety at home and in schools. And we are starting to develop community-based programs that will reduce fatal injuries.

I'd particularly draw your attention to a report entitled "Prevention of Injuries among Canadian Aboriginal People".

The report, done by a working group in our Medical Services Branch, lays out a strategy for action to prevent unintentional injuries to young Natives. That strategy will be discussed more fully by the group's chairperson in the two workshops on Aboriginal children.

The report shows that aboriginal injury mortality has been reduced by 12 per cent over the last decade.

Yet, the problem remains too severe. More than half of all childhood deaths in Native communities are due to injuries. Drowning, fires, and, among older Aboriginal children, vehicle crashes, claim far too many lives.

With the efforts of Aboriginal leaders, the government, and the work you are doing at this conference, we can contribute to a safe and better life for Native children.

The task at hand, for all of us, in all our communities, is formidable.

But we **can** stop the epidemic of injuries. As a society, we **can** show children the care and love that they deserve.

Doctor Louis Francescutti will be speaking to you on Friday. As many of you know, he is the founding Director of the Injury Awareness and Prevention Centre of Alberta.

The Centre has done exemplary work through its HEROES program. The program takes a multi-media approach to raising awareness of the means to prevent head and spinal injuries among teenagers.

The Prevention Centre was also the host of the symposium "Injury Control Objectives for Canada for the Year 2000", held in May of this year, which Health and Welfare Canada was pleased to support. I understand that the results of that gathering will be developed into an action plan during this conference. That is the kind of cumulative effort that will lead us to our goal of safer, healthier children.

We will continue to build on past accomplishments with the Canadian Children's Safety Network. The Network is a mechanism for communication on these issues between the Canadian Institute of Child Health, other health organizations, consumer groups, professional associations, business, and governments.

Our Department is glad to contribute to the continuing work of the Network. It will help put in place an effective, and broad-based structure that will bring us together to fight for injury prevention.

And Health and Welfare Canada plans to involve the Canadian Children's Safety Network, whenever possible, in making decisions that will prevent injuries to children.

Our commitment to help eliminate injuries that can be prevented goes hand in hand with our other commitments to children.

To reach out to the abused child, the poor child, the hungry child. To the unacceptably high number of children with mental health problems.

And we are reaching out --- with programs like the National Native Alcohol and Drug Addiction Program, the Family Violence Initiative, and with support for mental health programming.

Through the Children's Bureau we will put in place Canada's Action Plan for Children. The Plan is our response to the Declaration of the World Summit on Children. Some of you have expressed interest in this endeavour, and more details will be available when the Plan is completed.

Canada also intends to ratify the United Nations Convention on the Rights of the Child by the end of 1991.

Through the Convention, Canadians will express their hope for a future that is worthy of the dreams, the energies, the destinies, of the world's children.

Whether our work is directed toward our own country, or out to the entire planet --- our goal remains the same:

Every child should be able to reach his or her potential.

To reach that goal, all children should live in good health.

Which makes your work here even more important.

You believe that we can reduce, and even eliminate, the single greatest killer of our children.

And, I share that belief.

Together, we can build conditions for our children to be born, grow, and develop in good health and in safety.

Thank you.



# Speech / Discours

Speaking notes for  
the Honourable Benoît Bouchard  
Minister of National Health and Welfare



To the Canadian Mental Health Association  
1991 National Conference on Mental Health  
Ottawa, November 27, 1991

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I want to thank you for inviting me to participate in your 1991 mental health conference. It gives me an opportunity to acknowledge the Canadian Mental Health Association's contribution to promoting mental health and effective mental health services in communities across Canada.

For sixty-five years now, the CMHA has served and represented the interests of consumers and family members, volunteers and community workers. You have provided family support, education, crisis intervention, after-care and other services where they are most needed -- in the community.

I am proud of the partnership between Health and Welfare Canada and the CMHA -- a partnership that goes back many years. We have worked together to develop policy, and consulted on issues such as chronic mental disorders, mental health and the workplace, mental health and women, children and youth, and the particular circumstances of immigrants and refugees. Issues such as these must continue to be at the forefront of our discussions.

We have found common ground on many issues and on strategies to improve the delivery of mental health services. My department proposed a framework for examining mental health issues in the 1988 discussion paper entitled "Mental Health for Canadians: Striking a Balance." That document is reflected in many of the themes expressed in your conference program for the next few days.

A major theme that is finding a growing consensus is the need for community reinvestment: we need to find more ways to balance our spending on mental health services in institutional settings and in the community; society also needs to allow for a greater role for self-help programs and make sure that consumers and family members have more control over decisions and processes that affect them.

Many of the key decisions on spending priorities are, of course, within the jurisdiction of the provinces. They are taking steps to achieve a new balance in resource allocation despite the financial constraints that governments are facing today.

Over the years, Health and Welfare Canada has played an important role in promoting the improvement of mental health services. We have recognized that mental disorder is only one determinant of mental health and that there are many areas which have not traditionally been addressed by the health care system.

That is why we are also looking at programs that support research, community initiatives, information-sharing and mental health promotion. By funding work on behalf of victims of family violence, and by providing Sustaining Grants for National Voluntary Organizations such as the CMHA, we provide direct or indirect support for innovative work on mental health.

On another level, our partnership with the provinces under the Canada Assistance Plan agreements provides social assistance and welfare services to those in need. Many of these services support mental health to varying degrees and in different ways.

The federal government shares the cost of comprehensive rehabilitative programs for physically and mentally disabled persons and halfway houses for people who are making the transition from institutional care to the community.

But our work in supporting mental health does not end with cost sharing for these social service and health care programs. My Department funds research on a wide range of health issues, including mental illness, Alzheimer's Disease and AIDS. And our special responsibility for delivering health services to Status Indians living on reserves includes programs to address addiction and family violence problems associated with the disruption of traditional lifestyles among Canada's Inuit and First Nations.

So our role in researching and promoting mental health and in improving and supporting mental health services is extensive and varied. We know that no one part of the puzzle can provide a complete picture of the solution to mental health issues.

So while we wait for research to make further breakthroughs in the treatment and prevention of mental disorders, we recognize the importance of providing effective support for consumers at the community level. And we believe that, by making consumers, family members and volunteers full partners with professionals and others involved in mental health, we can make better use of our resources and ensure more complete and responsive services.



Effective partnerships must be an important part of our strategy for community reinvestment, and such partnerships begin at the community level. Sharing your views and your knowledge with Members of Parliament in your "Charge to the Hill" will help them to recognize that mental health is a concern that goes beyond the voluntary, institutional and professional services available in their city or region.

Every community can take a wide range of actions to promote mental health. Every decision that affects people has the potential to improve or impair their mental health. You know that. Canadians need to hear that message. Telling community leaders such as your MPs is one important step toward getting that message out.

We have to emphasize the connections between mental health and many of the other critical issues of our day. It is time to reach beyond our health and social service systems and expand the circle of Canadians concerned with mental health.

It is important, for example, for consumers, their families and friends to participate in designing and implementing responses to mental health issues.

That brings me to another reason why I believe that it is important for you to be speaking to your government leaders at all levels and representatives of business, labour and other groups: there is no one quick answer.

Some years ago, we might have created a large, national program and spent lots of money to achieve goals that were set here in Ottawa. Well, times have changed. We don't pretend to have all the answers. Government cannot do it all --- government cannot do it alone.

Today we realize that big issues may require five or ten or twenty or a hundred different solutions involving various governments, business, labour and community groups. We can still deal with the big issues. But we have to tailor the solutions to the specific needs of provinces, communities, and individuals.

Like other governments, we have come to realize that Canadians can agree on standards or values, but want to put them into practice in very different ways. So when you talk to your community leaders, let them know about the problems you see in your community. Talk about solutions. Think about how other levels of government and other organizations might be able to help. The solutions for your community may be solutions for other communities across the country.

In closing, I would like to invite you to read and discuss the federal government's response to the Standing Committee report on health care funding, which I will be tabling in the House of Commons. Our response articulates the government's position on health. We need to work together to find solutions to the challenges in mental health services in the nineties and beyond.

Your efforts will continue to be an important part of those solutions. I thank you for inviting me to share in your efforts today.

Thank you.





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# Speech / Discours

**Speaking notes for  
the Honourable Benoit Bouchard  
Minister of  
National Health and Welfare**

**Before the Child Health 2000 Conference  
Vancouver, February 19, 1992**

**Check against delivery**

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On behalf of the Government of Canada, I have the honour of welcoming you, to Vancouver for Child Health 2000, the world congress on health care for children.

This is a city where worlds meet. And over the next four days it will be a meeting place for a world of ideas on investing in the next generation of humanity. If there is indeed something called a New World Order, no agenda is more important than the health and well being of the world's children.

There is no doubt that we are living in a defining moment of world history. Years from now, historians will ask of this generation whether we seized this moment for the betterment of humanity.

The cold war is over. The world appears to have stood down from the nuclear watch. Real opportunity to ask where we are going next -- where we can focus our energies.

UNICEF's year 2000 goals can be achieved by the world spending another \$20 billion a year on children.

And of those 27 objectives agreed upon by the 1990 World Summit for Children, most can be achieved within existing knowledge bases, with available resources, with simple technologies. Imagine, most are within the healing power of the men and women in this room.

Consider the splendid example of the UNICEF immunization program, under the inspiring leadership of Jim Grant. It has been, and continues to be, one of the world's great success stories. It has achieved its goal of immunizing 80% of the world's children against six major diseases. As a result, it is saving the lives of 3 million children a year, 30 million in this decade.

In the past, urged on by the World Health Organization and UNICEF, the world has toiled with earnest for the survival of children. Our efforts have been most manifest in the global children immunization initiative which has been remarkably successful.

As well, it must be very gratifying for Dr. Jonas Salk to know that there are 2 million children in this world who are walking normally as a result of receiving polio vaccine under the immunization program. And one million lives are being saved every year from oral rehydration therapy.

I am pleased to be able to say that this country, its government and our Prime Minister have played a leadership role with UNICEF in reaching the 80% immunization target. We have now set 90% as our year 2000 target, and Canada has been pleased to contribute \$50 million to the next phase of this worthy program.

For as you know, there is still a world of work to be done on behalf of the world's children. A quarter of a million of the world's children are still dying every week.

That's a million children a month.

Which one of them, in other circumstances, might have kicked a football, drawn a poster, written a poem, or simply lived to be loved in the arms of his or her mother? These are not remote questions or issues. These are real questions. They can be dealt with, in the here and the now, with all your brains, all our devotion, and only a relatively few of our dollars.

Today's child and youth population of 2.8 billion exceeds the total population of the world in 1965.

"Investing in people," as the World Bank observed in its 1991 World Development Report, "makes sense not just in human terms but in hard-headed economic terms." And it cites hard economic data from developing countries in support of its claim that, as UNICEF notes, "better nourished children grow up to be not just healthier but higher-earning adults."

Sometimes, in the developed countries, we forget that we begin on the issue of child health from an envied position. For example, Canada has one of the lowest infant mortality rates in the world, 7.2 deaths per 1,000 births. That's down from 27 deaths per 1,000 births in 1960. And most OECD countries have comparable figures.

However, according to a report entitled Children's Well-Being prepared for the Centre for International Research in the United States, fully 97% of the world's infant mortalities occur in developing countries. And nearly one in every five deaths in the world is an infant death. Much work obviously remains.

These are global figures. But even within the developed world, among the richest and most privileged countries, we have to confront major issues of child health, child nourishment, child education, child poverty, children dropping out, and children from dysfunctional homes. These issues generally go together in a cycle of difficulty that all too often is repeated from one generation to the next.

Our challenge is to break that cycle where it has its tightest grip, on those we call children at risk.

When we see these kids -- we know we must act. These children are hurting and many will hurt all their lives because they will have been denied the opportunities to achieve their full potential. In a very real sense their future personal prosperity, emotional as well as financial, can too often be reduced.

Consider, for a moment, the 36,000 Canadian teenagers who become pregnant each year. These girls are less likely to finish high school, less likely to find lasting employment, less likely to marry than their peer group.

The poverty rate among single-parent families in Canada is nearly 40% as opposed to less than 10% for all families. In short, many single-parent families live in conditions of poverty -- conditions of risk.

Even if child poverty has actually been on the decline in Canada, the fact remains that, in this land of plenty, there are nearly 1 million young Canadians living in poverty. That isn't acceptable to Canadians. That isn't acceptable to my government. That shouldn't be acceptable to any government.

By international standards, the health of Canadian children is excellent. We have low mortality rates, quality health care, and a high level of nutrition.

But we certainly can do better when many children are hungry in this country. How can they learn in school when they are not receiving proper nutrition? How can we prevent child injuries? Child abuse? Child neglect? Child poverty?

How can we focus our efforts, within the more limited means available to all governments nowadays, to assist those children at risk?

For let there be no mistake. Our means are more limited. The range of policy options available is dictated by the financial constraints with which all governments must live.

The simple fact is that in the Government of Canada, the first 33 cents of every dollar we collect goes to service the national debt. That's \$43 billion that's not available for children at risk.

The lion's share of transfers to provinces and individuals, is paid out by my own department. Discretionary spending, the area where we must find funding for these children's issues, amounts to only about 15% of all government expenditures.

That's the world in which we're living. We have to make do with that. Which is not to say there is nothing we can do.

By focusing our efforts on children at risk, by working in partnership with the provinces, the voluntary sector, health care professionals such as yourselves, and other stakeholders, we can address these issues in an effective manner in Canada.

By investing in the earliest stages with programs for those children most at risk, we can achieve real benefits in the future. We need to place special emphasis on communities. For it is at the community level where we can bear the most fruit, where our children live and where we can have the greatest effect.

The focus on children at risk is the overriding priority with us. By kids at risk I mean those who are in ill-health, malnourished, who are abused, who live in poverty, or suffer from neglect. Tragically, and all too often, children at risk suffer from all of the above.

By focusing on those kids at risk, we hope to give them a good start in life -- a fair start. We want to put them on the same level playing field of health, nutrition, learning and employment opportunities as the rest of society's kids.

How can we do that in Canada? Well, we're going to make a good start in the coming weeks. I'll be announcing an Action Plan in which I hope to re-profile some existing resources, and allocate significant new ones, to address the issue of children at risk.

The focus of the Action Plan will be on the 2.6 million children in Canada under six years of age. That's fully 10% of our country's population.

It seems we will be leaving them a more peaceful world. We must also leave them a more prosperous world. We want to build a better tomorrow for them.

Every generation leaves the next a legacy. We all struggle to do our best for our children...to leave something for them...to give them a fair start. But as we make these efforts, we also recognize that our children will one day have to make their own way in the world. We can at best give them every opportunity. They must make their own prosperity.

Prosperity is not a commodity that can be bought or sold. It is not something that can be handed down from one generation to the next.

Prosperity is more a by-product than an end-product...a by-product of a healthy, happy, educated and motivated collection of people. Certainly prosperity has something to do with money, but it has a lot more to do with people.

Tomorrow's prosperity is in the hands of today's children. The legacy we must leave them is one of unrestricted opportunity. They must inherit from us a future that is wide open, free for them to make of as they will.

Each of us can make a contribution, those of us in government in a modest way, and those of you in health care in a significant way.



Because of your work a child has a better chance of being properly nourished, of being free from preventable disease, of surviving and growing and living a normal life. Perhaps the child whose life you save today may, himself or herself, save the lives of others in the next generation.

Such is the miraculous, healing, life-giving power of your profession. It is the real purpose of mankind. I congratulate you and wish you a most successful conference here and a most enjoyable stay in Canada.

Thank you very much.





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# Speech / Discours

**Speaking notes for  
the Honourable Benoît Bouchard  
Minister of National Health and Welfare**

**Before the YM-YWCA  
Ottawa, February 27, 1992**



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**Canada**



Last fall, I received letters and drawings from some young school children. I'd like to share their thoughts with you.

"Poverty", said one little girl, "is hiding your feet so the teacher isn't mad you don't have boots".

Another child wrote, "Poverty is telling people you forgot your lunch."

And a third boy, unaware of his simple eloquence, said "Poverty means no hot dog on hot dog day."

I can't express to you what heartache was captured in their paintings!

As a society, whether as members of government, voluntary organizations, business or labour groups, we must not fail our children.

No one can rest calmly with the knowledge that some children go to school hungry or do not have coats or boots in the winter or have been abandoned or abused by one or both parents.

Our task as a society must be to create conditions that will allow these children -- all children -- to flourish. Simply put -- children matter.

To help these children, we must help their families and help to support their parents. I want to illustrate for you what I mean.

Patricia is a single mother of two young children. She lives in a large urban centre in Canada and works as a store clerk. She earns 19,500 dollars a year. Making ends meet is often very hard -- running out of milk or warm coats are a constant worry.

Because Patricia chooses to work, she doesn't receive social assistance... she also doesn't receive many of the other benefits that social assistance recipients receive -- like free prescriptions and transportation.

Patricia works hard, loves her family, but needs our support. Today she gets a Family Allowance cheque of close to 70 dollars a month for her two children. And at tax time, she receives a variety of credits and benefits.

Most of the money she receives takes months to arrive and comes in one lump sum. It's difficult to stretch it out over the year.

Patricia's children sometimes don't have money for hot dog days.

Everyone knows someone like Patricia -- we understand her situation... many have lived her experience.

As a community, we need to honour her efforts to raise her children as best she can and recognize the work she does.

Canadians have long understood the need to support and cherish Patricia's children.

This was illustrated almost fifty years ago, in 1944, when a Canadian rose in the House of Commons and said:

"No political party and no group of citizens in Canada can validly claim to have a monopoly on the determination to see that the children of this dominion, who constitute by far our most valuable national asset, are given a square deal and the fullest of opportunities in the new and better era of tomorrow."

That Canadian was Gordon Graydon, then leader of the Opposition. The occasion was the introduction of the Family Allowance legislation.

Then, as now, the issue of children and family cut across party affiliations. The Prime Minister of the day, MacKenzie King told the House: "The family and the home are the foundation of national life."

These words were spoken almost half a century ago. Much has changed in the intervening years: Canada is no longer a dominion...the Progressive Conservatives are no longer the official opposition...But the wisdom of cherishing Patricia's children remain.

Times may change, governments may change but the importance of children remains steadfast.

Tuesday, our government announced a major change that will help Patricia and hundreds of thousands of Canadians like her. The proposed new child benefit reflects the changing times.

In the last decade, we have seen an explosion of two-earner families, a significant increase in single-parent working families, an increased movement of families, and the loss of traditional family and community support.

New technology has made it possible to design a benefit that is responsive to changing family circumstances. The design of the proposed new Child Benefit reflects these changed realities.

Before I talk more about the proposed new Child Benefit and additional steps to come, let me take you back to some of the events that led to this day.

In September 1990, the Prime Minister co-chaired the World Summit for Children at which seventy-one of the world's leaders committed their governments to act on behalf of the world's children.

In Canada we *have* acted... and we will *continue* to act.

Last May, the Throne Speech reiterated our commitment to children. It stated the objective simply: "...to see Canadian girls and boys better educated, better protected and better nurtured so that they can make their own contributions to Canada's future."

Last December, we completed another major step by ratifying the Convention on the Rights of the Child. The Prime Minister ratified the Convention with great pride because it was an illustration of Canadians' belief that our children, indeed the world's children, matter.

And Tuesday, we announced the proposed new Child Benefit in our budget.

It is a major step.

-- A two-billion-dollar step --towards improving federal support for children and families.

The new proposed Child Benefit will consolidate the existing Family Allowances, Child Tax Credits and Dependent Child Credit into a single monthly cheque beginning January 1993.

The Child Benefit would also include an additional amount for low-income working families.

It is a big step...one that I am very happy about. It builds on existing federal programs which total 15 billion dollars annually for children and families...it supports the roles of other governments and other organizations...it sets the stage for further important steps...

Since 1945, successive federal governments have made additions and adjustments to our child benefits programs. These programs have been modified on more than 20 separate occasions.

However, the result of all these additions and adjustments was a patchwork of benefits. It was complicated. As a result, Patricia and other Canadians have trouble knowing what benefits they will receive on behalf of their children.

As a system, it makes little sense. It is neither simple nor efficient. It tries to be fair, but it falls short in that regard too.



The proposed new Child Benefit will overcome these problems. It will be a simpler, fairer and more generous way of doing what several government leaders, commissions and committees have agreed must be done...provide additional help to Canadian children and families.

The proposed new Child Benefit has three main characteristics:

First, it's *simpler*. There's no additional paperwork to fill out. Under the present system, many of the cheques which are sent out are recovered at tax time.

With the proposed new Child Benefit, the full value of monthly payments will be tax-free. They are for parents to keep...to benefit their children.

It is an all-in-one cheque paid every month.

Second, it's *fairer*. The proposed new Child Benefit will be based on the overall income of the family, not on individual incomes. It will go to the families who need it.

It rewards the work effort of low-income working families. The children of families earning under 25,000 dollars per year deserve our help.

In many cases, the family earnings have failed to keep pace with inflation, despite their parents' continued efforts in the workplace.

To help these working families better provide for their children, there is a top-up of up to 500 dollars per family.

Lastly, it's more *generous*. Virtually all single parents and one-earner families will receive more. Annual benefits for low- to moderate- income families -- those with incomes below 50,000 dollars -- will *increase* by an average of almost 250 dollars a year.

Patricia and her two children will receive a total of about 2,500 dollars a year, an increase of 600 dollars. That averages to 50 dollars per month more than she currently receives. That 50 extra dollars a month could buy 8 litres of milk...three loaves of bread...a snowsuit...hot dogs on hot dog day.

The Child Benefit proposal amounts to a two-*billion*-dollar addition over the next five years. We should *all* be pleased with this initiative.

It was a *fiscally responsible* decision to increase benefits for families who need it.

We believe that fiscal responsibility is *itself* a social benefit. Our children must not inherit a Canada that is crippled by debt. What is added to the proposed new Child Benefit will not get added to the debt-load facing our children tomorrow.



Some will say that this is the end of universal social programs. I say this is a reaffirmation of Canadians' belief in fairness. I cannot justify sending a Family Allowance cheque or giving a Child Tax Credit to a family which earns a million dollars. It's just not fair.

I have said before that I love my three children equally but I treat them differently, that they are individuals. That's what fairness is about. Fairness is a fundamental characteristic of Canadians. That's why I'm confident Canadians will approve of this change.

But as I have stated, money alone is not the solution. By world standards, the health and well-being of Canadian children is excellent. Most of our children are well-nurtured, well-protected and well-educated.

But this is not the case for *all* of Canada's children. Many children are hungry in this country. Many are abused and neglected. Many face futures that are threatened by conditions of risk.

How can children learn in school when they are not properly fed every day? Many enter school poorly prepared to learn and drop out of school before they've acquired the necessary skills to succeed in life.

We must ask ourselves: How can we prevent risks from affecting a child's future health and well-being? Risks like low birthweight...childhood injuries...child abuse and neglect?

How can we improve a child's chances of developing into a happy, secure adult capable of making a contribution to society?

My response begins with a conviction...Children matter. I believe it is important that everyone hold that same conviction. We all have a stake in creating a society where our children are valued and are provided full opportunities for future growth.

This conviction springs from my belief that the improvement of children's lives is both an individual and a collective responsibility. As Sylvia Ann Hewlett put simply, "If we cherish our children, they will add to the wealth and strength of our country; if we neglect our children, they will drag this wonderful country down".

I want to make it clear that I see the proposed new Child Benefit as an important part...*but only one part*...of an overall approach to making life better for our children.

The problems facing our children today are many and varied, and require a range of solutions. We continue to re-work and update our approach to supporting children. We need to face today's realities with solutions designed for today, not yesterday.

I am therefore going to work with representatives of the provinces and key groups on a related package of initiatives directed more specifically toward helping young children who face serious risks to their future.

I will also be working with native groups and native women's groups to design programs for aboriginal children.

Too many of Canada's native children are at risk. Compared to the rest of the Canadian population, native children suffer greatly.

The federal government is committed to working with native people to improve the lives of their children. Native children and their families should be nurtured, educated and protected in a holistic way, consistent with their culture and values.

Real change can only be achieved through full involvement of native people in finding the solutions.

As the next step in the process of putting our plans for children into action, I am contacting provincial ministers, native and community leaders about the White Paper and future steps so that we can take action co-operatively.

Together, we can devise the actions that will address the pressing needs of children all across this country -- region by region, community by community.

In the spring, I will bring forward a package of initiatives as part of Canada's Action Plan for Children. Over the coming months, the various elements of our program for children will be put into place.

Every generation leaves the next a legacy. We all struggle to do our best for our children...to leave something for them...to give them the best start. But as we make these efforts, we also recognize that our children will one day have to make their own way in the world. But we can try to give them every opportunity.

Prosperity is not a commodity that can be bought or sold. It is not something that can be handed down from one generation to the next.

Prosperity is the result of healthy, happy, educated and motivated people. Certainly prosperity has something to do with money, but it has a lot to do with people.

Tomorrow's prosperity is in the hands of today's children. The legacy we -- all Canadians -- must leave them is one of unrestricted opportunity. They must inherit from us a future that is wide open, free for them to make of as they will.

Thank you.

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# Speech / Discours

Speaking notes for  
the Honourable Benoît Bouchard  
Minister of National Health and Welfare



The Action Plan on Health and the Environment  
Montréal, March 20, 1992

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First of all, I would like to thank "La Société du Vieux-Port de Montréal" and the Imax Theatre for their warm and cordial reception.

It was not by chance that "Le Vieux-Port" was selected as the site for the unveiling of my Department's Action Plan on Health and the Environment.

"Le Vieux-Port" is tangible proof of the importance of maintaining links between our urban citizens and their natural surroundings, in this instance, the waterfront.

Some fifteen months ago, the Federal government introduced its Green Plan for improving the environment. It is a massive effort on the part of the government, with more than three billion dollars being allocated for protection of the environment.

The Green Plan was designed to establish the strategic direction for the Federal government in matters pertaining to the environment.

The contents of the Green Plan were shaped to a large extent by the opinion and priorities that Canadians raised in the public consultations that took place in 1990.

In particular we were told that Canadians wanted information and knowledge that would allow them as individuals to pursue environmental initiatives.

The provision of information and the acquisition of knowledge are two of the principal activities that my Department follows to meet its mandate; "to help Canadians maintain and advance their health".

Included in the Green Plan are initiatives that impact directly on Québec, such as the Great Lakes/St. Lawrence Pollution Prevention Plan and the Montreal Parc des Îles Project. Both measures are aimed at preventing pollution and protecting our natural environment.

When we think of the environment, we think of polluted waters, air filled with contaminants, shorelines washed by petroleum by-products, the quality of our drinking water, and so on. We also think of our loved ones, and wonder about the legacy we are leaving to our children.

Just what are the effects of pollution on the health and well-being of all Canadians?

The link between environmental degradation and our health is not clear. We do know, however, that pollution will have negative effects on the health and well-being of Canadians.







How and to what extent toxic substances in the environment affect our health remains unclear and limited.

The Action Plan on Health and the Environment that I am announcing today is intended to take steps to gain a better understanding of the linkages between health and the environment.

The major focus of this plan builds on our strengths for carrying out research and adding to the already large information banks on health matters.

The key to making sound environmental decisions and in turn improving our health is built on information and knowledge.

People have told us that they want to be able to take actions that can make a difference.

I believe that the measures that I am announcing today are the best contribution that I can make to respond to this request.

To begin with, our Action Plan will involve fifteen concrete initiatives to be implemented immediately. The Government of Canada will commit 170 million dollars over six years to ensure that better and more informed decisions can be made concerning the environment and our health.

The fifteen initiatives of the Action Plan fall into four major areas:

1. \$68.5 million - Regulation and monitoring of the environment and its effect on health. We will introduce standards and environment surveillance measures to determine the negative impact on our health and well-being;
2. \$35.5 million - Groups at risk, including the protection of children, women and aboriginal populations;
3. \$40.5 million - Individual and community actions;
4. \$500,000 - Actions on the international level.

Included in the initiatives will be the introduction of legislation establishing quality standards for water.

This Bill will contain, among other things, higher standards for drinking water, thus responding to the concerns of the public and the drinking water distribution industry.



Another initiative concerns protection of the St. Lawrence. Our Action Plan provides precise and proactive measures for surveillance of groups at risk living along the St. Lawrence. I am thinking, among others, of children and pregnant women.

The St. Lawrence initiative complements the prevention measures envisaged by Canada's Green Plan for the Great Lakes/St. Lawrence region. One protects the environment, while the other does the same for health.

Whenever there is environmental deterioration, children, pregnant women and those living directly off their natural habitat are more vulnerable to the effects.

The Action Plan initiatives will prioritize the protection of these groups at risk by monitoring drinking water, studying the impact of Great Lakes pollution, developing a high risk area atlas, and increasing our knowledge of Northern and Arctic pollution.

Our goal is to ensure that the federal government facilitates access to information and the sharing of knowledge on environmental matters with the Canadian public. Health objectives require continuous interaction between individuals, communities and their natural environment.

In addition, today, the Minister of Fisheries and Oceans, Mr. John Crosbie, is announcing a \$44 million dollar program under Canada's Green Plan to assess the impact of toxic substances on fish and their habitat.

His department will undertake two major initiatives under the Fisheries and Oceans Toxic Chemicals Program. A national data base will be developed by 1997 to identify the levels and effects of toxic substances on major Canadian fish stocks.

Also, assessment activities on toxic substances will be increased in support of a national regulatory action plan to control toxic chemical under the Canadian Environmental Protection Act and the Fisheries Act.

In closing, I want to point out that our Action Plan is designed to position my Department as a catalyst for such exchanges and interactions. Information and knowledge must be made readily available to the public, the scientific community and special interest groups.

Individuals, communities, institutions and all levels of government have a role to play by promoting the changes that will improve the environment and our health.

My government will help Canadians adopt new habits that will make a positive contribution to our environment, and to our quality of life.



The beneficiaries of this Action Plan will be Canadians of all ages, our children, those who depend on the natural environment for their survival, and ultimately, the generations to come.

Actually, when each of us contributes in his or her own small way, we all benefit.

Thank you.





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# Speech / Discours

Speaking notes for  
the Honourable Benoît Bouchard  
Minister of National Health and Welfare



Renewal of Canada's Drug Strategy  
Montréal, March 31, 1992

10/92

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In 1987, under the leadership of Prime Minister Mulroney, the federal government announced its strategy to address drug-related problems which were posing an increasing threat to the health and well-being of Canadians.

Five years later, we can say with conviction that Canada's Drug Strategy has been a remarkable success and all Canadians can be proud of the progress made:

- Heavy drinkers have decreased by 25%.
- The number of drinks per week of young people age 15 to 19 is down 30%.
- Stimulant use is down 50%.
- Cannabis and cocaine use are each down 10%.
- The number of 16 to 25 year-old driver fatalities due to impaired driving is down 22%.

At the same time, we recognize that the problem of substance abuse still exists in Canada.

A recent survey tells us that a total of 400 young people - drivers, passengers, pedestrians, swimmers - still died in one year as a result of alcohol.

Drinking and driving remains the number one killer of Canadian teens, every year.

As well, police tell us that between 70 - 90 % of all crime across Canada is alcohol or other drug-related.

We know that whatever figures our surveys tell us about the use of drugs - including inhalants, street drugs like crack-cocaine- we can multiply those figures by 10 times in areas where our surveys cannot reach.

We also know that today's abusers of substances face greater risks than ever before. They are taking more potent drugs, administering them in combinations and by more dangerous routes. And they are consuming them more frequently.

The most important mandate that any government has is to protect the well-being of its citizens -- especially its children.

Obviously substance abuse is a threat to that well-being -- a threat to which we must continue to respond.

I am pleased today to announce the renewal of Canada's Drug Strategy. With this renewal, the federal government is honouring its long-term commitment with renewed funding of \$270 million dollars over the next five years.

In today's tough world of fiscal restraint, and in view of our collective struggle to decrease the deficit, I am pleased that this renewal constitutes an increase of nearly 18%.

With prevention and promotion as its key elements, the renewed Drug Strategy will build on the momentum of the first five years.

Along with its partners -- parents, teachers, community workers, business people, volunteers, the policy, health and social service professionals, and the different levels of governments -- the federal government will concentrate on reducing the harm caused by alcohol and other drugs.

Let's think for a moment what we mean by harm; to me, the damage done by substance abuse means sickness, death, social misery, crime and violence that place our communities and especially our children at risk.

Over the next five years Canada's Drug Strategy will target children at risk in prevention programming.

These children - the young, the abused, school dropouts, street kids, the unemployed, and off-reserve aboriginal youth - are hard to reach.

We will make every effort to reduce substance abuse in these special target groups. At the same time we will continue the programs that we know have been reaching each new generation of school children.

Prevention is the heart of our Strategy... for it is just as important to nurture a child as it is to rehabilitate an adult.

Our Strategy is a balanced one that has been an example to many countries around the world. We recognize the importance of preventing the onset of alcohol and other drug abuse. And, at the same time, we recognize the importance of enforcement and the need to reduce the supply of drugs.

In the coming days, my colleagues, the Honourable Doug Lewis, Solicitor General, the Honourable Otto Jelinek, and the Minister of Revenue Canada, Customs and Excise, will also be telling you more about initiatives in the enforcement area.

As lead Minister of Canada's Drug Strategy, I want to both thank and encourage all the partners of the Strategy. Substance abuse is everyone's concern and everybody's business.

People who are experiencing difficulties with alcohol and other drugs are not alone. There are people in every province, territory and most communities willing to help.

It is by working together - all of us - parents, teachers, business people, volunteers, health and social service professionals along with all levels of government - that we can maintain the momentum of our distinctly Canadian Strategy.





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# Speech / Discours

Speaking notes for  
the Honourable Benoît Bouchard  
Minister of National Health and Welfare

Brighter Futures  
Toronto, May 4, 1992





Ladies and gentlemen:

Today should be a special day for me and I hope, for you. I would like to talk to you about Canada's children and to present to you what I would like us, as a nation, to do for them.

Could we have a call to action? A call to all Canadians to focus on children - especially on the children who represent the segment of our society that disturbs us, that we would prefer not to face.

I wonder if this will just be seen as a political act with political benefit?

I am sorry but I am just a politician - more particularly, responsible for the children's file.

But, I truly believe that much has to be done for the children you have just seen.

For once, after 8 years in government, I will tell you what I want to do without saying anything about money. Don't worry, there *is* money. But my message goes beyond that. It is a message that says *Children Matter*.

I know that it is not very original to say that all children matter. But I want you to know who the kids at risk are and above all, to know that they exist and that they need your help.

I will do what I can, but we know more and more, particularly for me, that governments alone cannot do all that should be done. You are the important players and the message today is for you - for everyone, members of the press, professionals, parents, all Canadians.

So what can we do for kids in Canada?

We live in a blessed nation - there's no doubt about that. A nation rich with the resources and traditions that provide most of our children with all they need to grow up in a healthy, secure environment.

We live in a nation which - en passant- needs to be protected and saved. A nation where parents and caregivers demonstrate - through their persistent dedication that children truly matter - that children's needs are their personal priorities - that they know and welcome their responsibilities to our youngest citizens.

And yet, we live in a nation where, for some children, the early years have to be forgotten because instead of building healthy foundations on which to grow, they struggle to hold their own, sometimes slipping backward.

We would prefer, each of us, to forget that children at risk are here; we would like to convince ourselves that they live in another country or on another planet.

Yet there are one million of them in Canada.

They are called children at risk: What are children at risk?

Do we really know what an inadequate birth weight does - one which does not provide the strength to combat sickness?

Have we really seen the results after a few years in the life of a weak child?

What do we say when the nutritional intake is below that necessary to support the remarkable growth of infants and toddlers?

What kind of life does it prepare a child for?

What do you think about family living conditions which drain the energies of parents, making it hard for them to meet all of the many demands of parenting?

Do you think that parents will go on to have other kids? Is it not a fertile ground for big consequences - violence, abuse, reject?

How do we feel when those parents don't find in our communities support to help share the burden of raising their children?

Will they just give up?

These are the kind of risks that some children experience. Again, *one in five* of our children. This is a statistic we don't like to look at - we don't like to face. But we must.

If our society is to accept the basic principle that all children matter, then we must reduce these risks.

I am not sure that my voice is strong enough to convince Canadians. I need yours.

All of our children must have the opportunity to grow into healthy, confident, capable young people ready to make the most of all that the future can offer.

Don't ask me to determine who can be neglected. I won't.

The message today is based on that belief - a belief that I hope all Canadians share - *Children Matter*.

To begin, in September 1990, at the World Summit for Children, the Prime Minister, and leaders from 70 nations, signed a Declaration calling for national action plans on behalf of children.

They recognized what parents and caregivers everywhere know so well: we are creating the future every day through our children.

I feel strange in saying that the health and well-being of children today is the surest measure of the strength and vitality of nations in the years to come. I feel strange because I fear that, too often, these are just words.

But maybe they won't be if Canadians will work to develop two initiatives, among many, that can help Canadian children.

We will also be working internationally, to assist children at risk. Problems affecting children are not contained by borders, neither are the solutions.

I want to move in areas in which we have jurisdiction, areas in which, we, as a government, can make a difference.

As well, I want to be with those who assist others in their work - provinces, territories, communities, non-governmental organizations - those who work at the ground level - those who know the problems and the solutions and can achieve direct results.

This is our agenda for children.

I want to see *Brighter Futures*.

But, before I detail our two new initiatives I want to make one thing very clear.

Governments never have all the answers, here particularly, the federal government does not have all the answers;

For many, many years, we believed and we said the opposite. Personally, sincerely, I increasingly believe that the more people who are involved, the more responsibilities that are shared, the more sensitive people become, the more chances children have to be helped.

Governments have to commit to partnerships with others - provinces, territories, non-government organizations, communities, families and children themselves - to discover the answers and to put them into action.

Some will criticize - they will say that this is political and that we are using children. But why? It would not be my role - the federal government does not have children - parents have children.

But governments can lead. Canada's Action Plan for Children is the first new initiative I want to share with you today. The Action Plan describes where we are today and outlines the challenges that the future holds.

Building on it over the coming years, Canadians from all walks of life, their organizations and governments can participate in a path of common cause, in the interests of children.

The *Child Development Initiative* is one challenge that must be addressed now and this is my second point. The challenge of helping children who are at risk, the risk of not getting a strong and healthy start in their early years of formative development is one we must face.

I am sad that I can't share all my impressions of my visits to the Children Hospitals in Toronto and Vancouver where I saw many infants beginning their life under poor conditions - babies born with a mother addicted to drugs; with illnesses; or with little strength.

I would like to have the power to make this disappear, that this didn't happen to vulnerable children. I have seen different choices in the struggle against those realities.

The Action Plan and the Child Development Initiative will build on these premises. We have ratified the Convention on the Rights of the Child and introduced the proposed Child Benefit in the last Budget. Together, these four initiatives make *Brighter Futures*.

In the next few days, few weeks, few months you will be hearing more. More about prevention, about promotion, about protection, and about partnership. Especially about partnerships.



In that time, I encourage everyone to recognize that a national effort on behalf of our children in the sum of the individual efforts of each and every one of us.

Working together can take many forms - participating in a voluntary organization, giving a single parent a break. Any effort helps with the partnership.

Today, I am committing the federal government to a role in these partnerships.

It is a role that will be defined in detail in the months to come with my colleagues in the provincial and territorial governments who already carry significant responsibilities in child welfare, parental support programs and education.

This is a role that will be defined with the hundreds of non government organizations, associations and communities that work everyday with our children.

If we are to work successfully and efficiently in supporting parents and families as they address the conditions of risk some children face, we all will have to work together.

Duplication of programs, overlapping efforts, and the waste of re-inventing good ideas deprive children and their parents of the resources they need to help them.

Cooperating, and creating new ways of doing things together, that build on our jurisdictional responsibilities and our individual strengths, will make our resources go farther.

This is an important investment in our future. We must start with the children. Ultimately, our strength as a nation is reflected in our care for those who are most vulnerable.

In fact, the future of Canada, means nothing if so many children continue to be at risk?

Together, we can make their lives better. If we start at the beginning, than we can know that we have built a better Canada.

Not only in a charter or a constitutional document, but in the real world.

Because children are the real future of the nation. It is more than words - it is life.





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# Speech / Discours

**Speaking notes for  
the Honourable Benoît Bouchard  
Minister of National Health and Welfare**



**Meeting of representatives  
of international organizations  
Hosted by UNICEF  
Montreal, May 5, 1992**

**Check against delivery**

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I would like to thank UNICEF for organizing this event and inviting me to spend some time with you to talk about Canada's Action Plan for Children and some new initiatives we have launched for children in Canada and in developing countries.

I appreciate this opportunity to share some of our insights with you and hear some of your thoughts on the directions we are taking.

I feel fortunate to be Minister of Health and Welfare in a country like Canada.

I do not have to deal on a daily basis with problems of widespread malnutrition, or a lack of medical supplies, or inadequate water and sanitation services.

I feel fortunate, but not complacent.

Our prosperity compels us to share. When our Prime Minister served as co-chair of the World Summit for Children in 1990, he did so on behalf of Canada's children and with a sense of openness to the problems faced by children throughout the world.

I know that Canadians share that openness and willingness to share.

When I think of an average Canadian child growing to adulthood in today's environment, I see her sitting across the table from a young adult who has grown up in a country that cannot offer the same level of education, health services and community facilities.

Their equal birthright is not reflected in their experiences in this world. But they share the same world. And their opportunities must be better shared.

Canada's Action Plan for Children is not just about Canada's children.

It is about our sense of responsibility for caring for our children and the children of the world. I will leave it to Mme Landry to share with you some of the details of our international commitments.

I'd like to share with you some of the insights we've gained on the children in Canada who are not as fortunate as we'd like to think all our children are. We call them children at risk.

I have a short video that conveys, in a way that demonstrates our feeling about these issues, the depth of the problems some children face in our prosperous country. For too many children, this is the face of childhood in Canada.

[SCREEN VIDEO]

As Minister of National Health and Welfare, I've had to ask myself some difficult questions. The United Nations Development Program calls Canada the best country in the world in which to live. So why do we have one million Canadian children at risk?

It is not because we lack essential services. We have an enviable health care system and universal access to education.

It is not because we don't care. We have family and child support programs to give parents and other caregivers much of the support they need to raise healthy children in a nurturing environment.

So why are so many Canadian children at risk?

Canadians like to believe that all of our children are on the pathway to prosperity and self-fulfilment that we see as our birthright. The facts tell us that this is not true.

The facts tell us that there are two pathways for children in Canada.

One pathway is a bright one that includes a complete education, good health, and supportive relationships.

The other pathway is filled with shadows. For too many children, childhood is shadowed by illness, injury, a lack of education, the breakdown of family relationships, and the absence of role models and caregivers who can help them develop a sense of self-esteem and positive life goals.

Children live in the shadows because too often, we cannot or do not make good use of the programs and supports we already have. We let children live in the shadows when we do not live up to our responsibilities to protect them.

The shadows of deprivation, neglect, and injury can lead children to further risks. Without a good start in life, children may find it too difficult to learn the basic skills they will need throughout their lives. Without a nurturing environment, children may be vulnerable to substance abuse.

Without intervention from alert and caring family, friends, or professionals, they may suffer the travesty of physical abuse.

We know the answer to most of the problems these children face. We have to do a better job of putting our skills together in ways that work.



The Government of Canada's Child Development Initiative is a series of new measures that will help us make better use of the skills and programs we have developed, and find new answers and create new solutions, to the problems that continue to challenge us.

It is the fourth of a series of initiatives that the Government of Canada has taken since the Prime Minister joined other world leaders in a commitment to improve the lives of children in all countries:

- Canada ratified the United Nations Convention on the Rights of the Child in December, 1991.
- The Government of Canada proposed a new Child Benefit that will provide more generous and better targeted support to Canadian families.
- The federal government has prepared Canada's Action Plan for Children, which I released Monday. It is a blueprint for the federal government's response to the challenges faced by children and families in our country and around the world.
- The federal government is making a five-year commitment to reduce conditions of risk among children, through the Child Development Initiative.

The Child Development Initiative, and all of these measures, are important investments in our future.

If we intervene effectively, early enough in the lives of children at risk, we can get them on the bright pathway they deserve.

We can prevent the challenges they face early in life from developing into adolescent problems and adult crises. We must start with the children.

The Action Plan describes the situation of children in Canada today, the programs and supports provided by governments and non-government organizations, and the responsibilities that are carried by parents and other caregivers and professionals.

It sets out the challenges, for all the social partners, that have been identified in recent reports on the status of children in our society. The challenges are many.

But all the partners - governments at all levels, parents, business, labour, non-government organizations, professionals, and children themselves - have roles to play.

We believe that our strength as a nation is reflected in our care for those who are most vulnerable. It is up to all of us to create brighter futures for our children.

I invite Mme Landry to explain some of the initiatives we are taking on behalf of children in developing countries.

Thank you.

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# Speech / Discours

Speaking notes for the  
Honourable Benoît Bouchard  
Minister of National Health  
and Welfare Canada



Kids First Conference  
Ottawa, May 7, 1992

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Thank you, Mark, for an introduction that sets challenges - to match your energy and dedication and a challenge to respond to the call for future generations.

You and your peers will indeed take over the institutions of this country, and thus, it is your duty to judge our actions and to express your judgements in a clear and strong voice.

We live in a blessed nation - a nation rich with the resources and traditions that provide most of our children with all they need to grow up in a healthy, secure environment.

We live in a nation where parents and caregivers demonstrate - through their persistent dedication - that children truly matter.

- ◆ that children's needs are their personal priorities.
- ◆ that they know and welcome the responsibilities to our youngest citizens.

And yet, we live in a nation where, for some children, the early years are difficult years, years when, instead of building healthy foundations on which to grow, they struggle to hold their own, sometimes slipping backward.

As most of you know, in 1990, Prime Minister Brian Mulroney acted as co-chair of the World Summit for Children, which culminated in the World Declaration on the Survival and Development of Children.

The Declaration called on all nations to "make an urgent universal appeal to give every child a better future." By signing the Declaration, the Prime Minister committed Canada to improving the situation of children in Canada and around the world.

Since then, the Government of Canada has responded by taking four steps. Four important steps that build our agenda for children. An agenda we call "Brighter Futures".

The Prime Minister took the first step on December 11, 1991. He joined young people from every province and territory to ratify, on Canada's behalf, the United Nations Convention on the Rights of the Child.

As a signatory to the Convention, Canada is saying to the world, in the strongest possible terms, "Children matter!"

The government took the second step in last February's budget. We proposed a new Child Benefit, to target more financial assistance to families with low incomes.

On Monday, we launched the next two steps in our path. But before I detail these, I want to say now what I said then:

Governments never have all the answers, here particularly, the federal government does not have all the answers.

But it is committed to partnerships with others - provinces, territories, non-government organizations, communities, families and children themselves - to discover the answers and to put them into action.

But governments can lead. Canada's Action Plan for Children calls on governments at all levels, parents, other caregivers, business, labour and all who care for Canada's children to work together.

To work together to address some of the many challenges we face in a society that is constantly changing.

The Action Plan describes the situation of children in Canada today. It looks at the programs and supports provided by governments and non-government organizations, and at the responsibilities that are carried by parents and other caregivers and professionals.

It sets out the challenges, for all the social partners, that have been identified in recent reports on the status of children in our society. The challenges are many. But all the partners have roles to play.

The Action Plan also contains a \$20 million "Partnership for Children Fund", announced yesterday by Minister Landry and myself, that focuses part of our international development work on the needs of children and youth in developing countries.

On Monday, I also detailed the Government of Canada's new Child Development Initiative, to address the specific needs of children at risk. I'd like to tell you something about that initiative, and about the thinking that lies behind it.

As Minister of National Health and Welfare, I've had to ask myself some difficult questions. The United Nations Development Program calls Canada the best country in the world in which to live. So why do we have one-and-a-half million Canadian children at risk?

Do we know what an inadequate birth weight does - one which does not provide the strength to combat sickness?

How do we feel when the nutritional intake is below that necessary to support the remarkable growth of infants and toddlers?



What do you think about family living conditions which drain the energies of parents, making it hard for them to meet all of the many demands of parenting?

How do we feel when those parents don't find in our communities support to help share the burden of raising their children?

These are the risks that some children experience. Again, *one million* of our children. This is a statistic we don't like to look at - we don't like to face. But we must.

If our society is to accept the basic principle that all children matter, then we must reduce these risks.

Canadians like to believe that all of our children are on the pathway to prosperity and self-fulfillment. The facts tell us that this is not true. The facts tell us that there are two pathways for children in Canada.

One pathway is a bright one that includes a complete education, good health, and supportive relationships.

The other pathway is filled with shadows. For too many children, childhood is shadowed by illness, injury, a lack of education, the breakdown of family relationships, and the absence of role models and caregivers who can help them develop a sense of self-esteem and positive life goals.

Children live in the shadows because too often, we cannot, or do not, make good use of the programs and supports we already have. We let children live in the shadows when we do not live up to our responsibilities to protect them.

Shadows of deprivation, neglect, and injury early in their lives can lead children to further risks as they grow up. Without a good start in life, children may find it too difficult to learn the basic skills they will need throughout their lives.

Without a nurturing environment, children may be vulnerable to substance abuse.

Without intervention from alert and caring family, friends, or professionals, they may suffer the travesty of abuse.

We know the answer to most of the problems these children face. We have to do a better job of putting our skills together in ways that work.

The Child Development Initiative will help us make better use of the skills and programs we have developed, and find new answers and create new solutions, to the problems that continue to challenge us.

It has four components: prevention, promotion, protection, and partnerships.

The *prevention* component will address the major causes of injury, illness, death, and mental health and development problems among children.

We will work with the provinces and territories, non-government organizations, health care professionals, researchers, and others, to develop long-term national goals to improve our children's health and development.

We can do much more, more efficiently, by focussing on prevention.

The *promotion* component will help build awareness and skills among parents and other caregivers, increase public awareness about issues affecting children and families, and reduce the incidence of low-birth-weight babies.

The *protection* component will include Criminal Code prohibitions against child pornography, help for the provinces and territories in enforcing child and spousal support orders, and expanded measures to locate missing children and to safeguard children involved in international adoptions.

The *partnerships* component will provide comprehensive support services for children at risk and their families. These community-based activities will be offered through partnerships with the provinces and territories.

Working partnerships will also allow these services to be offered in Indian reserve communities and Inuit communities.

The Government of Canada is committing \$500 million to these initiatives over the next five years, and continuing funding of \$170 million in the following years.

This is an important investment in our future. We must start with the children.

Ultimately, our strength as a nation is reflected in our care for those who are most vulnerable. Together, we can make their lives better, we can build a better future.

Thank you.

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# Speech / Discours

**Speaking notes for  
the Honourable Benoît Bouchard,  
Minister of National Health and Welfare**



**1992-93 Main Estimates  
Health & Welfare Canada  
Ottawa, May 7, 1992**

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Mr. Chairman,

I am pleased to be here, and I appreciate this opportunity to discuss, with you and your colleagues, the Main Estimates for 1992-93 for Health and Welfare Canada, and the Department's plans for the coming year.

I would like to introduce those at the table with me:

Ms. Margaret Catley-Carson, Deputy Minister of the Department, and

Mr. Raymond Laframboise, Assistant Deputy Minister, Corporate Management.

In response to the most pressing needs of Canadians which have come to the fore in the past year, our principal focus in 1992-93 is on the family.

Some of our principal programs designed to meet the needs of families include those dealing with family violence, child benefits, drug abuse, seniors programs and social assistance.

I would like to mention some of the figures in the Main Estimates. The total figure for all our programs is \$36.5 billion, a net increase of \$1.8 billion -- five-point-two percent over last year.

This increase consists largely of increases in statutory payments ---our restraints on other areas reflects our response to fiscal realities.

The largest budget items include:

- ◆ An increase of 601-million-dollars in old age security, guaranteed income supplement and payments for spouse's allowance;
- ◆ An increase of 598-million-dollars for payments to the provincial and territorial governments for the Canada Assistance Plan;
- ◆ An increase of 384-million-dollars for payments to the provinces and territories under the federal-provincial fiscal arrangements, and for post secondary education and health services; and
- ◆ An increase of 104-million-dollars for family allowance payments.

I'm sure that Committee members will agree that, in these times of difficulty for some Canadians, the government must carry out its responsibilities to help to alleviate economic pressures on families.



That is, to meet the pressing needs of children and senior citizens; to recognize the difficulties faced by the poor; and to support education and health services.

I announced on Monday, "Brighter Futures", a call to action for all Canadians on behalf of Canada's children.

"Brighter Futures" is made up of four government initiatives. Two have already been announced:

- ◆ The ratification by Canada on December 11, 1991 of the United Nations Convention on the Rights of the Child; and
- ◆ the proposed Child Benefit, which was announced in the February 1992 budget (2.1 billion new dollars over five years).

Two new initiatives were announced on Monday:

- ◆ Canada's Action Plan for Children, to provide the government's response to the 1990 World summit for Children and the Framework for addressing the long term needs of Canadian children; and
- ◆ the Child Development Initiative to reduce conditions of risk in which many children, particularly young children, find themselves.

The Child Development Initiative, \$500 million over five years, will be developed and administered in close partnership with the provinces, territories, First Nations and Inuit communities and non-government organizations.

The five-year Initiative will also provide ongoing funding to ensure continuity and effectiveness for programs in the areas of prevention, promotion, protection and partnership through community action.

*Prevention:* \$50 million will be provided for programs designed to obtain better information on the causes of childhood illnesses, injuries and death, and to better address concerns such as nutrition and children's physical and mental health.

*Promotion:* \$73 million will go towards programs to provide information to parents about reducing conditions of risk and about the care and nurturing of children.

*Protection:* \$17 million will be provided for programs to complement existing federal initiatives to protect children from threats to their well-being.



*Partnership through community action:* \$200 million will be provided for community action programs to assist local groups deliver health and social programming to high-risk children.

These community action programs will be carried out in close cooperation involving agreements with provincial and territorial governments.

In addition, \$160 million will be used for community-based programs to support Indians on-reserve and Inuit communities to deal with problems affecting Native children and families.

"Brighter Futures builds on the theme of partnership and on the recognition that a national effort on behalf of our children requires the individual effort of each and every one of us.

To continue the focus and maintain the momentum for children, we have established the Children's Bureau within the Department. It will fulfil the commitments made in the International Convention on the Child.

One example of the action we are taking is the project, Caring Communities: Community-Based Action to Prevent Child Sexual Abuse.

In keeping with our approach to build up partnerships with every group, every person who wants to contribute, we are addressing this problem where it can best be confronted: in the community.

The people who know best what their children need, and how to provide it, are the people in the community. Health and Welfare Canada is providing comprehensive support for this kind of partnership which can produce effective results.

This is one part of our comprehensive Family Violence Initiative, which is aimed at the problems faced by all members of the family.

Another example of our focus on the family is our recent renewal of Canada's Drug Strategy.

Five years ago the Prime Minister announced the original program.

Since then,

- ◆ Heavy drinkers have decreased by 25 per cent.
- ◆ Drinking by teenagers is down 30 per cent.
- ◆ The use of stimulants is down 50 per cent.
- ◆ The use of cannabis and cocaine is down 10 per cent.

Unstated in these figures are the improvements in the lives of thousands of families. Of course, there is much need for more improvement.

The Government's allocation of 270-million-dollars over the next five years is a measure of the commitment by my Department to work -- with many partners -- to confront drug abuse, the scourge of too many Canadian families.

Another commitment is our Action Plan on Health and the Environment. We all realize that, to have a nation which is a worthy legacy to our children, we must take action in those areas of our environment which pose risks to our good health.

I'm sure none of us can accept unnecessary risks to the well-being of our families.

Our Action Plan, budgeted at 170-million-dollars, provides funding for 15 separate initiatives in four areas: regulation and monitoring; protecting groups at risk; facilitating individual and group action; and contributions to international programs.

One example is a proposed Drinking Water Safety Act, to legislate drinking water quality in the federal domain, and to establish standards for materials and chemicals used in water, and water treatment devices.

On another major matter, I am glad to report to you that there is a growing sense of mission and rapport among Ministers of Health for the provinces and myself regarding the future of health care.

We have had a series of productive meetings, and our next conference will be with the finance ministers. We all look forward to productive results in dealing with the problems of financing national health care in Canada.

I am confident that federal-provincial cooperation will lead to improving the financial strains that we are experiencing in this area.

Mr. Chairman, this is a brief résumé of some of the most important areas covered in the Main Estimates for the Department of Health and Welfare. As I have indicated, the main focus of our activities in the coming year is the family -- successfully overcoming the various burdens I mentioned, good health, financial security -- for children, for senior citizens, for all family members that need support.

I'm sure many Members have questions and I will be glad to answer them now. Thank you.

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# Speech / Discours

**Speaking notes for the  
Honourable Benoît Bouchard  
Minister of National Health  
and Welfare Canada**



**13th World Organization of Family Doctors  
Vancouver, May 9, 1992**

**Check against delivery**

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Good evening,

On behalf of the Prime Minister of Canada, the Right Honourable Brian Mulroney, I would like to say how honoured we are to host your 13th World Conference and to welcome you to Canada.

The theme of your conference "Family Medicine in the 21st Century" is especially appropriate for me to share with you some of my thoughts on a subject that is very close to my heart - our children.

I especially want to talk to you this evening about a group of children that you are all so familiar with - children at risk. Canada has just been rated the number one country in the world to live in according to the UN Human Development Index.

But Canada also has one million children at risk - that's one in five of our children - and some statistics say that this number underestimates the problem.

I don't want to preach to the converted, I don't have to tell you what the consequences are when a child grows up with poverty, ill health, poor living conditions, abuse or neglect. You and your colleagues have told me.

Instead I want to tell you what *I* want to do and about the government of Canada's agenda for children. About the four steps we have taken to try to give our children better tomorrows.

That is why I call our agenda Brighter Futures. Brighter Futures is a call to action for all Canadians on behalf of Canada's children.

Our first step was taken by the Prime Minister when he and children from across the country ratified the UN Convention on the Rights of the Child.

As many of you know, the convention laid out a set of principles and standards that asked the world to respect its youngest members.

Our second step was a proposal for a new Child Benefit. To bring greater financial resources to children, especially those in low income families.

By combining, simplifying and streamlining our current programs, we have created a fairer, more responsive benefit for families. And by adding additional resources for low income working families we have targeted those who need our help.

On Monday, I introduced Canada's Action Plan for Children, the Government's response to the 1990 World Summit for Children. It is a blueprint for action to support children and families in Canada and around the world.



This week, I also announced our fourth step, one that opens the door for many steps to follow: a new Child Development Initiative.

The Child Development Initiative is a long term program designed to address the conditions of risk in a child's life. Many of the programs will focus on the earliest years - at a time when intervention can produce incredible results.

Under our Prevention initiative, we will provide programs to obtain better information on the causes of childhood diseases, injuries and death, and to better address such concerns as nutrition and physical and mental health.

This week I visited two hospitals that specialize in children where I met doctors, psychologists, social workers and many of your contemporaries.

I discussed with them what *they* believed would be important as well as a new program we will be introducing called "What Works". This will gather research, from across the country and information in order to provide the best network for the people who care for our children.

Secondly, I believe the promotion component will also be key to the success of our programs. In order to have response to our call to action we must sensitize Canadians, we must provide awareness of the problems and must show how every Canadian can get involved.

There will also be a "healthy babies" component directed at pregnant women and new mothers. We will continue to promote breastfeeding. Canada has made remarkable strides.

Our third element is protection, I strongly believe that our strength as a nation is reflected in how we protect our most vulnerable.

Finally, we are devoting the largest amount of funds to an area called Partnerships. There are two streams through which this money will flow. We have devoted almost one third of our funding to native and Inuit communities. Some of our most tragic situations occur on native reserves.

The second stream of partnership will flow into community action. Our Government will work closely with the provinces and territories to identify common priorities for high risk young children.

We will fund local groups and local projects because I have learned that the best answers come from those closest to the problems.



I am committing my Government to a new way of doing business for our kids. To publicly acknowledge that we don't have all the answers, that we can't fix all the problems, unless we get the help of every Canadian.

I want to be in this for the long haul - for a partnership for our future, for Canada's future, for the future of Canada's children.

Canada has also recognized our obligations to the children of the world. Last year, Canada provided about 350-million dollars in Official Development Assistance, through the Canadian International Development Agency for activities related to children.

And in Canada's action plan, we committed 20 million dollars to Canadian organizations dedicated to helping children at risk around the world.

An excellent example of an ongoing partnership is the work of the College of Family Physicians of Canada, in cooperation with Health and Welfare Canada, in its HIV/AIDS Information and Awareness Campaign.

Over the next two years, this campaign will allow family physicians from every provincial chapter across Canada to conduct educational seminars on HIV infection and AIDS for their physician colleagues.

These seminars will focus on ways family physicians can provide community-based care for Canadians living with HIV infection and AIDS.

Furthermore, the College of Family Physicians of Canada has been an important partner with my department and 7 national health professional associations in the development of a national strategy to enhance preventive practices of health professionals across Canada.

In this context, a strategy document has been released this week by my Department emphasizing the role of physicians and other health professionals in prevention and health promotion.

I want to thank you for giving me the opportunity to address you this evening, letting me share initiatives of my department that Canada can be very proud of.

I also want to publicly acknowledge the vital work you do every day. You provide the human touch to medicine. In an era of high technology, family physicians around the world are looked to as caregivers, mentors and friends.

I strongly believe that people are what makes a nation great and your work keeps our peoples strong.

As Minister of Health and Welfare, as Minister responsible for children, I say thank you.

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# Speech / Discours

Speaking notes for the  
Honourable Benoît Bouchard  
Minister of National Health and Welfare

Youth and Cancer: The Challenge for Canada  
A Public Forum, July 2, 1992



21/92

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It is an honour for me to be here to welcome all of you to Health and Welfare Canada's first public forum on youth and cancer.

I particularly wish to acknowledge the presence of international specialists in the field of cancers affecting youth. We are fortunate that our forum follows the 1992 annual meeting of the International Association of Cancer Registries, the gathering which attracted these specialists to Ottawa at this time.

Each of us has an important role in the fight against cancer. But we must pay special attention to childhood cancers. After injuries, cancer is the leading cause of death among children aged one to 14 in Canada. The opponent we face is tough. Scientists estimate that there will be 1,300 new cases of childhood cancer this year in Canada.

Your presence at this forum is evidence of the shared commitment and co-operation which enables us to plan for and to know that we can achieve brighter futures for our young ones.

In May this year, I announced Brighter Futures, my government's action plan for children. We designed the Initiative to benefit primarily the more than one million Canadian children who are at risk because of poverty, ill health, unhealthy living conditions, neglect or abuse.

Brighter Futures is a call to action for all Canadians on behalf of Canada's children. The time has come for each and everyone of us to work together to change the reality for Canada's children who are at risk.

With ongoing funding over the next five years, we will develop and assist programs in the areas of prevention, promotion, protection and partnership through community action.

I am pleased today to announce the launch of a major disease prevention program within the Brighter Futures Initiative. Over the next four years, my department will spend \$5.6 million on the Childhood Cancer Control Program.

Using data provided by provincial and territorial cancer registries, the Childhood Cancer Control Program will collect information on risk factors and will document methods of treatment and cure rates.

The program will be developed in collaboration with parent support groups, health care providers, voluntary agencies, as well as the provincial and territorial governments.

Consensus workshops will use this information to recommend childhood cancer control programs based on prevention and the widespread use of effective treatments.

This concentrated effort is a result of the desire, not only to end the suffering cancer can cause, but to prevent this disease from occurring in the first place.

We have good reason for hope. We have had tremendous successes in the treatment of childhood cancer, particularly in treating the most prevalent form of the disease - leukemia.

Now we are striving to achieve the same measure of success in preventing childhood cancer.

This is where the Childhood Cancer Control Program will be very helpful. Scientists will analyze existing cases of childhood cancer to identify the most likely causes of the disease.

This will give Health and Welfare Canada and the health community a solid foundation of information for determining strategies to control and prevent childhood cancer.

As Minister of National Health and Welfare, I recognize the need for discussion and consensus among all interested parties. And that is what I hope we are facilitating here today.

Today's forum is the first step in an on-going process of consultation and collaboration with our partners in the fight against childhood cancers. This process will continue throughout the Childhood Cancer Control Program.

Your meeting here today sets the stage for the Childhood Cancer Control Program. The success of the risk assessment and cancer treatment surveillance that follows rests largely on your continuing co-operation.

I am grateful for your participation, particularly the six non-governmental organizations who are partners with Health and Welfare Canada in presenting this forum:

- the Carleton District branch of the Canadian Cancer Society;
- the Canadian Society of Pediatric Hematology and Oncology;
- the Candlelighters Childhood Cancer Foundation Canada and the Ottawa Candlelighters Childhood Cancer Trust;
- the Children's Hospital of Eastern Ontario; and
- the Pediatric Oncology Group of Ontario.



"Brighter Futures" builds on the theme of partnership and on the recognition that a national effort on behalf of our children requires the individual effort of each and every one of us.

I am hopeful that today's forum will convey a strong message to all Canadians about an important health concern for our country: cancer in youth.

We can only build a brighter future for Canada by cherishing all our children - particularly our children at risk.

Thank you.





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# Speech / Discours

Speaking notes for  
the Honourable Benoît Bouchard  
Minister of National Health and Welfare

Canadian Association of Paediatric Hospitals  
Winnipeg, September 30, 1992



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Good morning ladies and gentlemen.

I am very happy to be with you this morning and to have an opportunity to say a few words about one of my favourite subjects -- children.

As Minister responsible for children I have visited many hospitals and children's facilities from coast to coast and I have to tell you that there is nothing, absolutely nothing, that touches me as deeply as a suffering child.

I know that life without suffering is an impossibility but I also know, as do all of you, that much of the suffering of our children is unnecessary.

Over one million children in this country are at risk because of poverty, ill health, inadequate living conditions, neglect and abuse.

That means one in five of our children start their lives on an unhealthy pathway. Every child will face obstacles as they grow to adulthood. But for those children on an unhealthy pathway these obstacles can be overwhelming and can last a lifetime.

But by working together to identify these obstacles and remove them all of our children can have a healthy start.

One in five of our children are at risk. That's a terribly disturbing statistic and one that I know the Canadian Association of Paediatric Hospitals is working to change.

It's significant that your 25th annual conference coincides with the second anniversary of the World Summit for Children, September 30.

The World Summit was a turning point that breathed life into the United Nations Convention on the Rights of the Child. Canada is a proud signatory.

In May 1992, I announced *Brighter Futures* on behalf of the Government of Canada. I believe this initiative to be one of the most important made by my government.

*Brighter Futures* consists of four parts: the Ratification of the UN Convention; the Child Tax Benefit, just passed last week in the House of Commons; Canada's Action Plan for Children; and the Child Development Initiative.

Canada's Action Plan for Children includes a section entitled "Challenges for Canadians". As Canadians, each and every one of us should take up these challenges and play a role in the well-being of our children.

I must congratulate you for your initiative in using "Challenges for Canadians" as a framework for your recent strategic planning retreat.

This is an excellent example of the kind of partnership that *Brighter Futures* was intended to stimulate; the kind of partnership that will be so important to the future of our children.

Another example is, of course, the Sentinel Surveillance System. This system is a vital national program set up to improve the accuracy and timeliness of information on childhood diseases and injuries.

It marks a collaboration between you, as health-care providers, the research community and government.

For twenty-five years you have been building this kind of collaboration and that is why I am proud today to provide you with details of the continuing funding of the Sentinel Surveillance System through *Brighter Futures*.

Part of this system is the Canadian Hospitals Injury Reporting and Prevention Program (CHIRPP), where participating hospitals collect information on the nature and causes of injuries in children treated at their institution.

CHIRPP was intended to provide us with a national picture of childhood injuries. To date, we have gathered tens of thousands of reports from Canada's ten paediatric hospitals and from three general hospitals.

But if we are to have a true national picture, more hospitals must be involved.

Therefore, I am happy today to announce that CHIRPP will receive \$7.1 million in order to expand its national network.

And I am very pleased that the computers used are donated by Hewlett Packard Canada. This is a fine example of how business can get involved.

In order to develop effective injury prevention programs, in order to alert educators, legislators and others to the specific problems and possible solutions we must have good information.

Information will form the basis of prevention and treatment in the area of childhood diseases as well. The Childhood Sentinel Disease Surveillance Program is another component of the Sentinel Surveillance System.

This is a unique program which will develop a national disease surveillance program based in public health units. Overall, we will be spending \$7.5 million over 5 years to expand our knowledge of childhood diseases.

In fact, a pilot project on childhood asthma surveillance is planned in five public health units.

Information gathering, risk assessment and the development of prevention and control programs are the heart of the Sentinel system. We know from existing research that after injury, cancer is the second leading cause of death in children over one year of age.

In July, I announced the establishment of the Childhood Cancer Control Program, another important component of the Sentinel Surveillance System. This program again represents collaboration between health-care providers, researchers and government.

The Childhood Cancer Control Program is a national system of surveillance and risk assessment specifically for cancers which occur during childhood.

It will use existing provincial cancer registries to examine trends and develop prevention strategies. It will also involve consensus in examining treatment therapies.

We will be providing \$5.6 million dollars over 4 years in ongoing funding for operation of this program.

Information is the key. In order to prevent disease, we must understand the risk factors, we must understand who is at risk. I believe that this program will give us such information.

But illness and injury are only part of the many problems which confront our children today and may confront them in the future.

Over the next two days you will be exploring some very tough and critical issues -- child neglect, the impact of the disadvantaged child on society, the health of our aboriginal children and the ethics of research involving children.

Breaking the cycle of child neglect will require a fundamental restructuring of the way we view child health issues in this country.

And we know there can be no real solution to the plight of our disadvantaged children without a rethinking of some of our basic values and our notion of progress.

Over one million children in Canada show all of us in a very dramatic fashion that our response cannot be one of business as usual.

Ladies and Gentlemen we have a long road ahead of us in our efforts to give all our children a healthy start chance in our world of rapid change and uncertainty.

I believe that in partnership we can all make a difference. We can work toward a time when all of our children are on healthy pathways.

I look forward to hearing about the outcome of this important annual meeting and I wish you continued success in your worthy and much appreciated service to our children.

Thank you.



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# Speech / Discours

**Speaking notes for  
the Honourable Benoît Bouchard  
Minister of National Health and Welfare**



**Canadian Cardiovascular Society - Annual Meeting  
Ottawa, October 21, 1992**

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Thank you for the opportunity to address your annual meeting. It is a great honour and a pleasure to be here this morning.

This has been a very important year in the battle against cardiovascular disease. Up to 50 per cent of all deaths in industrialized countries are caused by heart disease and we know that it is a serious emerging problem in developing nations.

An impressive amount of work was accomplished at the International Heart Health Conference in British Columbia last May, which ended with the release of the Victoria Declaration on Heart Health.

Senator Dr. Wilbert Keon represented your society on the Conference Advisory Board, which produced the Declaration.

This landmark document is bound to raise the public and political visibility of cardiovascular disease as a major health issue. The Declaration, in fact, calls the widespread prevalence of cardiovascular disease a "modern epidemic."

The Policy Blueprint in the Declaration, which represents the consensus of a number of representatives of national and international organizations, in itself is a major achievement.

As someone with more than a passing interest in heart health issues, I strongly support the Victoria Declaration and I want to assure you also that my Department fully supports the Declaration's Call for Action.

The Declaration calls upon the public and private sectors to join forces in a number of areas including: educating the public, creating political will to promote public health, building partnerships, and, most importantly, applying and extending the scientific base.

Decades of research have produced knowledge about health promotion approaches that can either prevent or postpone heart disease and stroke.

The major risk factors for cardiovascular disease can be prevented or controlled. Multiple health benefits result from the control of risk factors such as smoking, high blood pressure and high blood cholesterol.

In addition to declines in heart disease, the incidence of other non-communicable diseases -- such as cancer and lung and liver disease -- also goes down.

The Canadian Cardiovascular Society is a significant driving force behind the research that underlies the current emphasis on our capacity to implement preventive measures.

Your Society is working with the Heart and Stroke Foundation of Canada on a vision for cardiovascular disease in this country. I understand that the Task Force on Cardiovascular Disease held a successful meeting in Montebello, just a few days ago. .

I congratulate you on the initiative and look forward to learning about the results of its deliberations.

Your agenda calls for promoting cardiovascular research, preventing cardiovascular disease and empowering the public to make positive lifestyle changes. My department strongly endorses these objectives.

Not so long ago, cardiovascular disease was a matter for a doctor's office. Today, heart health is an issue in the public health domain. There is a general consensus that heart health needs to be dealt with in the context of a broadly based health promotion approach to the entire population.

Intersectoral co-operation, working with groups such as yours, is a vital part of the success of our national strategy for the active promotion of heart health.

The Canadian Heart Health Initiative is a joint effort involving my department, provincial health departments, the Heart and Stroke Foundation of Canada and numerous other professional health associations.

As scientists and practitioners, you have a major role to play in this national agenda.

I encourage you to tie research proposals to public policy concerns -- to bridge the gap between science and policy, as the theme of the International Heart Health Conference so aptly pointed out.

The moment is right for collaboration between public health practitioners and scientists with a clinical or research perspective.

The research agenda of the future should cover a spectrum of concerns. A broad multidisciplinary effort is needed, extending from basic laboratory research and clinical research to research at the community level.

The Medical Research Council and the National Health Research and Development Program support basic and clinical research.

This support, together with contributions from the Heart and Stroke Foundation of Canada, has fostered the the development of a core of cardiovascular researchers that is second to none.

One very important outcome of the International Heart Health Conference was the creation of a dynamic, broadly based network that includes these Canadian researchers and decision makers, all of whom are committed to the concept of heart health.

Unquestionably, we have made significant progress.

However, we all know that considerable work still lies ahead. Here in Canada, surveys tell us that two out of three Canadians have more than one risk factor for heart disease. The surveys also tell us that a large segment of the Canadian population is not aware of the causes of heart disease.

This is another gap we must bridge -- the gap between the scientific knowledge about lifestyle risks and the everyday life of Canadians. We have already made considerable gains in the fight against smoking; I am confident we can make comparable heart health gains.

We are in the fortunate position of knowing that collectively our work will have a profound impact on the health of Canadians. As your colleague, our distinguished Senator Keon said in an address to the Canadian Senate last June:

"The scientific information we now have before us in the field of heart health care is that even fairly limited expenditures by governments on health promotion and disease prevention in the short term can help to develop community health coalitions, encourage the private sector and media to assist in promoting healthier lifestyles, and, in the longer run, produce considerable savings for governments in the treatment of health problems."

We are on the verge of making major gains in the fight against cardiovascular disease. We are in this position because of the research advances achieved by groups such as the Canadian Cardiovascular Society.

I want to compliment you on your forward-looking approach and the comprehensive range of issues you will address at this annual meeting -- issues extending from the clinical management of cardiovascular disease to health promotion activities.

I also want to take this opportunity to convey my thanks to your President, Dr. Edon Smith, as well as Drs. Keon and Dagenais -- who devoted so much time to the organization and success of the International Heart Health Conference.

Your work is an investment in the health and quality of life of all Canadians. We need your work. I am pleased to be able to work with you and I assure you again of my support.

Thank you.





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# Speech / Discours

**Speaking notes for  
the Honourable Benoît Bouchard  
Minister of National Health and Welfare**



**on the occasion of  
the 35th Congress of the  
Conseil québécois pour l'enfance et la jeunesse  
Quebec, November 13, 1992**

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Monsieur Bouchard, Madame Trépanier, distinguished guests, award winners and delegates ...

Anyone who has ever tucked a small child into bed at night and later looked in on them in their peaceful state of sleep knows the pleasure of parenthood. For a majority of parents, our children are our greatest joy and source of satisfaction.

Canadians can take pride in the fact that our children are among the healthiest and most secure in the world. As families and as a society we provide them with the best in nutrition and shelter.

We equip them with an education that ensures their future. Equally important we give them our love, our support and our confidence that they can achieve their dreams.

Yet despite best intentions, very often due to circumstances beyond their control, too many parents leave as their legacy a life of misery and despair. Of this country's 6.6 million children, almost one million are considered at risk.

Each of you in this room knows their stories all too well. They are the victims of poverty, ill health, unacceptable living conditions, neglect and abuse. Their dreams too often become nightmares.

Thanks to the work of many of you gathered here, their stories sometimes do have happy endings. Canadians like yourselves, dedicated to improving children's welfare, have made a dramatic difference in the lives of society's lost children.

The federal government is equally determined to improve the plight of our most precious resource. Each year we direct more than \$15 billion dollars to Canadian children and their families.

From the *Family Violence Initiative* to the *Stay-in-School Program* to the *National Drug Strategy*, Canadians are contributing to a better tomorrow for today's kids.

Earlier this year my Department unveiled *Brighter Futures*, our federal response to the 1990 World Summit for Children. It is aimed especially at this country's children most at risk. It defines our priorities and charts our course for the future.

*Brighter Futures* began with the ratification by Canada of the United Nations Convention on the Rights of the Child in December of last year.

The government took the second step in last February's budget with the new Child Tax Benefit, to target more financial assistance to those who need it.

It will provide additional support – \$2.1 billion over the next five years – for low and middle-income families with children to give them a stronger start in life.

**Brighter Futures** continues through Canada's Action Plan for Children. It sets out a blueprint for all the social partners – calling on governments, parents, caregivers, business and labour – to cooperate and collaborate for the benefit of our children.

And not just those in our own backyard. The Action Plan contains a \$20 million **Partnership for Children Fund** that focuses part of our international development work on the needs of children in developing countries.

**Brighter Futures** also includes Community Action, a five-year \$500 million program geared to prevention, promotion, protection and partnerships through community action.

Whether addressing child abuse or accident prevention, social or physical diseases we recognize there must be more than just band-aid solutions.

This package of long-term programs are aimed squarely at the youngest and most vulnerable in society. The programs will be administered in close cooperation with the provinces, territories, First Nations, communities and non-governmental organizations.

As proud as I am of this initiative, I must make it clear that no single organization can or should answer all the questions. Finding solutions must be the shared responsibility of parents, educators, community groups and all levels of government.

I am here tonight to congratulate you and to thank you for your personal commitment and contributions to Canada's kids. I am also here to encourage you to continue to battle for equal opportunities to give every child in this country a fighting chance.

For 30 years, le Conseil québécois pour l'enfance et la jeunesse has provided leadership and assistance in this province through prevention and health promotion programs.

You have proven not only that children matter. You have demonstrated that we can make a real difference in children's lives – by volunteering time, exercising leadership and by refusing to accept the status quo.

Members of the Working Group which produced *Un Québec fou de ses enfants* can be particularly proud of the effort which went into this progressive report.

I welcome this opportunity to exchange ideas about ways we can learn and work together to help young people. Through dialogue and consultation we can come up with lasting solutions for society's disadvantaged children.

Although we may not always agree on approaches I am sure we agree that we all have unique, and complementary, roles to play in the future of the next generation.

If the challenges are great, the promise of real progress has never been better. There is a growing recognition that an investment in our children is an investment in our future.

We now know that prevention is better than repair. Rather than spending our limited resources rebuilding shattered lives, we must build a solid foundation from which our future prosperity can grow.

Children, who might otherwise become a burden on society and unfulfilled in their own adulthood, can look forward to life as happy, healthy, well-adjusted adults.

What greater gift could we give our country? What better bequest from our own generation?

We can and will bring about meaningful change if we put our hearts where our policies are. I have no doubt that, together, we can do it.

Thank you.







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# Speech / Discours

Speaking notes for the  
Honorable Benoît Bouchard,  
Minister of National Health and Welfare



Research Centres on Family Violence  
and Violence Against Women  
Montreal, November 13, 1992

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Good morning! I am honoured today to co-sponsor an important initiative which I believe will take us forward in our efforts to eliminate family violence and violence against women from our society.

Montreal will be one of the five locations across the country to establish a research centre on family violence and violence against women.

The research team based at the Université de Montréal will be awarded \$500,000 over five years to conduct research into the causes of and solutions to family violence and violence against women.

The Centre will bring together academics from the Université de Montréal, Université Laval, and McGill University and their community partners such as Relais-femmes and La Fédération des CLSC du Québec.

The new Centre here in Montreal, joined by those being established in London, Ontario, Vancouver, Fredericton, and Winnipeg, will help us understand the occurrence of violence and ultimately how to prevent it.

What do we know so far about family violence and violence against women?

We know that abuse happens. We know that at least one in every ten Canadian women is assaulted by her husband or partner. In fact, my officials tell me, that it is probably far greater than one in ten.

We know that twenty-five percent of girls and ten percent of boys are sexually abused before the age of sixteen.

We know that both the victims of abuse and the abusers themselves span generations and are from all walks of life.

What we don't yet know is *why* abuse happens. The research we have conducted to date has shown us that there could be many reasons why a man assaults his partner and that control over women is a factor.

Are you familiar with the expression "rule of thumb?" We often use it to depict a standard against which we measure something. But do you know where the expression comes from?

It comes from the legal sanction that a man could strike his wife with a stick, provided the stick was no wider than his thumb! It was a rule designed to help husbands keep their wives and children in line.

Our laws have progressed far beyond the "rule of thumb" but some of our attitudes are still firmly anchored in inequality.

How do we get to the root causes of violence and, after understanding the causes, how do we act to stop family violence and violence against women?

The Research Centres which are being announced today are a major step in the right direction.

Each centre will undertake research into different aspects of the problem. Piece by piece the puzzle of why abuse happens will become clearer.

Montreal is no stranger to violence and has not been exempt from the sorrow it causes.

In 1989 a man killed fourteen young women at the Ecole Polytechnique.

Following that tragedy the Canadian Association of University Teachers proposed to the Prime Minister that centres on family violence and violence against women be established to research the determinant factors, be they social, psychological, economic or otherwise, which contribute to the violence.

We agreed and responded positively by issuing a call for proposals last year.

The overwhelming response both heartened and convinced us that Canadians abhor violence and want to participate in its elimination.

Forty-three groups representing partnerships between universities and community service organizations submitted applications.

The winning proposals were chosen through a competitive, peer review, adjudication process. In many cases it was not easy to choose from so many excellent proposals.

We were fortunate to have a partner to see the centres of excellence dream become a reality.

The Social Sciences and Humanities Research Council which co-sponsors the centres with Health and Welfare, is the primary federal agency for supporting research, training and communication of research findings in the social sciences and humanities.

The Council has a strong record in working with partners from the public and private sectors to support research on important issues which affect Canadian society.

The proposal from Montreal was strong and compelling. It proposed that researchers and community workers would seek to identify the root causes of wife abuse, child abuse, and elder abuse. The needs of adolescent victims would be examined.

Three Quebec universities, together with Relais-femmes which represents thirty women's groups and la Federation des CLSC du Quebec would develop practical, useful approaches to help victims and prevent further violence.

Members of the team would evaluate and develop prevention and intervention programs while investigating the factors which contribute to family violence.

The partners in this important new venture are uniquely qualified to undertake this important work: they know the subject well and they are committed to adapting the research into action.

The composition of the team, with members from the academic community and frontline workers in the field, provides both analytic and intervention expertise.

Working together as partners, they will discover new ways to prevent the violence, and will develop more effective intervention models.

Partnerships such as this are the only way we can hope to solve this issue.

When the \$136 million *Family Violence Initiative* was announced last year, we stated that no law or program passed by government could make the problems disappear.

Governments can provide leadership and help mobilize people. But it is the efforts of countless individuals, agencies, and organizations which will make the difference.

Women have long been in the forefront of this issue, helping victims to become survivors. But, my view is that the problem belongs to all of us - we are dealing with people issues, society's issues.

We must carry on in our efforts to think much more systematically about women's health needs and determinants.

Together with the provinces and territories we have produced a coherent framework to guide our policy and program development. It is an excellent start.

But there are other health issues which impact on the health and well-being of Canadian women. These range from breast and lung cancer to mental health, chronic and degenerative disorders, substance abuse and poverty.

Governments, in partnership with communities and individuals, need to continue efforts to come to grips with these problems. Together we can make a healthier Canada for all her citizens.

I commend the Université de Montréal, Laval, McGill, and your many community partners for your contribution to a healthy Canada.

As you proceed in your search for solutions to family violence and violence against women take heart that we will overcome the problem.

My very best wishes to all of you as your project begins.





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# Speech / Discours

**Speaking notes for  
the Honourable Benoît Bouchard  
Minister of National Health and Welfare**



**Canadian Centre on Substance Abuse  
Award of Distinction  
Ottawa, November 18, 1992**

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29/92



Ladies and gentlemen,

It's a great pleasure to announce this afternoon, during Drug Awareness Week, and National Addictions Awareness Week, a new award, the Canadian Centre for Substance Abuse Award of Distinction.

The award honours those people who provide leadership in Canada's effort to combat the abuse of alcohol and other drugs.

The Canadian Centre on Substance Abuse collaborates with many partners – individuals and organizations – in the battle against substance abuse. Canada's Drug Strategy has three key elements: prevention, treatment and enforcement.

This national Centre coordinates policy, research and information.

In hundreds of communities across the country, professionals and volunteers work daily to help those vulnerable to substance abuse, and those already suffering from its effects.

This is often a difficult, demanding, even thankless task.

At times, it can be discouraging.

This new award, the CCSA Award of Distinction, is tangible recognition of those who continue a centuries-old tradition: the tradition of coming to the assistance of those in society who are trying to overcome difficulties in their lives.

The Award comprises an original sculpture and a one-thousand dollar cash prize. In its design, the sculpture strikingly portrays the individual and the collective strength of the human spirit.

In establishing the Award, the Centre consulted a broad cross-section of professional and lay people from coast to coast, who make up the national community working in the field of substance abuse.

Criteria for the award include achievement in the areas of prevention; education and information; treatment; enforcement; and research and policy.

We cannot measure the full value of the exceptional contributions of many professionals and volunteers who work in this field.

But we can recognize their service, thank them for their devotion, and honour them for their accomplishments.

Candidates will be chosen by representatives of the provinces and territories, and these names will be submitted to a national selection committee, culminating in the presentation of the Award in November, 1993.

However, groups and individuals in the addictions field have suggested a special presentation of the Award this year.

It gives me great pleasure to announce, this afternoon, a special presentation of the Award, to one of Canada's outstanding citizens – Dr. David Archibald.

Countless Canadians know David Archibald as the eminent contributor to the struggle against alcohol and other drug addiction over the last 40 years.

His lifetime of dedication to the cause is an extraordinary story of accomplishment which I cannot begin to describe this afternoon.

His record of generous service is extensive – from establishing the Addiction Research Foundation of Ontario in 1950; to years of work around the world for the United Nations; to his leading role in the formation of this Centre as a part of Canada's Drug Strategy.

He has earned the acclaim, respect and esteem of his peers, and of the many, many Canadians who have benefitted from his work.

His achievements as a scholar, an administrator and an advisor are far-reaching. His place as a distinguished leader, at home and abroad, is secure in the history of his chosen field.

You can learn more about this outstanding Canadian in the information kit we have prepared for you.

David Archibald will be the guest of honour at reception at the Minto Place Hotel in Ottawa, on Thursday, December 3rd, when he will receive the CCSA Award of Distinction.

Thank you.



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# Speech / Discours

Speaking notes for the  
Honourable Benoît Bouchard  
Minister of National Health and Welfare

Introduction of  
*Canada's Food Guide to Healthy Eating*  
Royal Agricultural Winter Fair  
Toronto, November 20, 1992



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Ladies and gentlemen, good morning.

For many of us here this morning, this is a very special day.

The skills, knowledge and experience of hundreds of you, from coast to coast, have produced *Canada's Food Guide to Healthy Eating*.

People like you have dedicated yourselves to providing Canadians with food, and guiding us in healthy eating. The new Food Guide will be a key tool in serving the people of Canada in the 1990s.

The new Guide has come a long way since the first version was published 50 years ago under the title, "*Canada's Official Food Rules*."

Somehow, I don't think that, today, "Official Food Rules" would be a very persuasive title --with teenagers or any one else.

But in 1992, the 50th-anniversary of the Food Guide, the principles remain the same --to offer Canadians a practical and realistic guide to making food choices for healthy eating, based on sound nutrition and food science.

As Minister of National Health and Welfare, I want to thank you for your contributions to the revisions to the guide, the first update since 1982.

It demonstrates to all Canadians what we can achieve with cooperation and partnership.

*Canada's Food Guide to Healthy Eating* recognizes that a key to health is not any one food, one menu, or one day's meals, but the overall pattern of the foods we eat over the long term.

Healthy eating is a basic means to promote good health. It also contributes to an overall sense of well-being and helps people to look, feel and perform better.

The key messages are to enjoy a variety of foods from each of the four food groups and to choose lower-fat foods more often.

You will also notice, printed on the Guide, the "Healthy Canada" logo.

This logo refers to a new approach that I have asked my Department to develop. This approach will link our health programs together and provide Canadians with practical information to make healthy choices.

The Food Guide is an effective tool for individuals and families to improve their health. Of course, as we all know very well, better nutrition is not a simple, one-step process. In implementing the Food Guide, we face a number of challenges.

It's important to ensure that Canadians have access to foods for healthy eating. That they be able to read and understand information on nutrition. And that they can have confidence that the foods themselves are safe and nutritious.

These indicate the continuing efforts we must take to ensure that, with the new Food Guide, we do make a difference.

Millions of Canadians of all ages are eager to learn about healthy eating. We want to reach children, students, parents, athletes, home makers, workers, business persons, senior citizens -- people in all walks of life.

We want to establish and reinforce healthy eating habits, to contribute to their overall sense of well-being. To help people look, feel and perform at their best.

Our challenge is to get the ideas and values of the Guide into the minds and hearts of all Canadians.

If we work together on this new task as we have so far, I'm sure we can enjoy an equal success.

Again, my thanks and congratulations to each of you who contributed your talents, knowledge and experience to the Guide.

I invite you now to join me in putting the Guide to the test.

Thank you.



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# Speech / Discours

Speaking notes for  
the Honourable Benoit Bouchard  
Minister of National Health and Welfare

Quebec Council on Tobacco and Health  
Conference on Tobacco Consumption and Youth  
Montreal, November 25, 1992



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Ladies and Gentlemen, good morning.

It is a privilege for me to be here today to welcome you to this special conference on tobacco consumption and youth.

As all of you know, tobacco use is the single most preventable cause of premature death and disability in Canada. Use of this toxic, addictive product regularly ends in tragedy.

Slowly, surely, insidiously, tobacco kills. It kills our friends and it kills our relatives.

In fact, tobacco products kill an estimated 38,000 Canadians every year. Many more suffer from tobacco-related premature disabilities.

Thousands of Canadians, most of them children, are duped every year into starting to smoke. The trap is set; once addicted, it is very difficult to quit.

Canadians insist that their scientists and health care systems be at the forefront of new investigations and treatment of illness. Canadians insist that we respond to new developments with lightning speed.

Since 1964, the year that the surgeon general of the United States first publicized the link between cigarette smoking and death, more than 600,000 Canadians have died prematurely of tobacco-related illnesses because they have been unable and unwilling to quit.

Because of collaborative efforts by all levels of government and partners in the health community, smoking rates have dropped in Canada in recent years. Smokers are smoking less, and the number of smoke-free spaces is growing.

Canada's co-ordinated health promotion approach, called the *National Strategy to Reduce Tobacco Use*, has achieved this success by means of educational, legislative, research and public policy initiatives.

However, a significant obstacle is blocking our forward momentum -- the tobacco industry.

In this roadblock nothing is more evident than the unacceptably high numbers of young persons who start to smoke each year.

Rarely does anyone start smoking after the age of 18. Therefore, the tobacco industry relies on children as young as 12 years of age to replace smokers who have quit or who have died prematurely of tobacco-related illnesses.

Each year at least 70,000 Canadians under the age of 19 start the life-threatening habit of using tobacco. Last year -- 1991 -- teenagers spent more than \$698 million on tobacco products.

The problem is greatest among teenage girls who now start smoking in larger numbers than teenage boys. The Canadian health community will study this problem in detail in January during National Non-Smoking Week, when it focuses on the theme -- Young Girls and Smoking: Not A Pretty Picture.

Here in Quebec, just over 22 per cent of all young people between the ages of 15 and 19 now smoke regularly -- a total of 98,000 teenagers. Fortunately the rate has dropped from 29 per cent in 1989, but it is still the highest in the country among comparable age groups.

The alarming extent of this nation-wide problem only strengthens my resolve to achieve the smoking reduction targets of the *National Strategy to Reduce Tobacco Use*.

Recent setbacks are frustrating, but they too only strengthen my resolve.

I will not be pushed into inaction. Neither will any health minister who comes after me.

As you know, the Canadian tobacco industry has challenged the *Tobacco Products Control Act* which prohibits tobacco advertising and regulates labelling and monitoring of tobacco products.

The Quebec Court of Appeal heard the Attorney General of Canada's appeal on a lower court ruling that the Act is unconstitutional and we are awaiting the decision from the Quebec Court of Appeal.

We know that every public health move we make might be challenged. Yet I will face that at every turn.

Tobacco smuggling is another source of great frustration. This continuing problem is particularly serious because it provides children -- and adults -- with cheap tobacco. Tobacco smuggling jeopardizes the success we have achieved to date.

We must examine new options to deter smuggling.

I intend to push forward with the government's next move to advance the objectives of the National Strategy for the good of all Canadians.



It is my hope to introduce into Parliament by the end of this year revised legislation prohibiting the sale of tobacco products to minors. The new legislation will significantly reduce the access to tobacco by young persons.

My provincial health colleagues all share the federal government's concern about the high number of young smokers. In fact, we have recently initiated a joint task force between the federal government and the provinces to coordinate our efforts.

A new law in British Columbia limits access to tobacco products in that province by children and youth. A vendor can lose his or her right to sell tobacco by regularly selling tobacco to children and youth.

Recently, Nova Scotia and Prince Edward Island banned the sale of Toddler Packs -- packages of cigarettes that contain fewer than 15 cigarettes.

The Ontario Ministry of Health is developing a new tobacco strategy, in part to address the problem of tobacco consumption by youth.

A strong health promotion framework is an essential umbrella for legislative initiatives to restrict access to tobacco products by minors.

Ongoing efforts of the *National Strategy to Reduce Tobacco Use* include health promotion programs which primarily emphasize prevention.

My Department has developed or is working on a range of anti-smoking programs, some in collaboration with partners such as the Canadian Cancer Society and the Canadian Council on Smoking and Health.

Programs are designed for youngsters in day care settings, children in recreational fitness settings, teenage girls, parents of adolescents, health educators and others. Materials include printed resources, a video and an upcoming television spot that promotes smoke-free lifestyles.

In addition, Health and Welfare Canada is designing a teen-smoking cessation program, called *Quit 4 Life*.

Research is another important approach to the problem of tobacco consumption by youth.

Researcher Georges Létourneau has completed a report entitled *Smoking in Groups at Risk: the Francophones of Quebec*. We are fortunate, by the way, to have Mr. Létourneau as a speaker at this conference.

In all our endeavours our aim is to help young persons achieve a satisfying quality of life.

Tobacco policy does not exist in isolation. It dovetails with a major federal effort to provide young people with the best possible environment in which to develop their unique capacities.

This initiative, called *Brighter Futures*, consists of federal government undertakings to aid the more than one million Canadian children at risk because of poverty, ill health, unhealthy living conditions, neglect or abuse.

Programs within the Community Action component of *Brighter Futures* acquaint prospective parents and the community with the potential risk to a developing fetus of smoking and exposure to second-hand smoke.

Maternal smoking is now definitely linked to low birth weights and the associated physical and intellectual deficits that restrict an individual's progress for the rest of his or her life. These problems also increase demands on our already-strained health care and social welfare systems.

Most of the diseases caused by smoking and treated in hospital involve complex, expensive diagnostic and therapeutic measures.

In 1989, six-and-a-half million smokers cost the health care system almost \$3 billion. Moreover, the families of the 38,000 smokers who died that year lost about \$8 billion in anticipated income as a result of their loved ones' premature deaths.

These tragic, premature deaths diminish society as a whole. There is no monetary figure that can reflect the pain and suffering brought about by 38,000 needless deaths each year.

To maintain the universality and affordability of our health care system, all efforts must be made to prevent the unnecessary tragedies caused by the use of tobacco products.

Society simply can not afford the toll that tobacco takes, either in human loss, suffering or in the tremendous financial burden that society as a whole must shoulder.

Our combined health promotion efforts are particularly important in light of recent setbacks created by the tobacco industry. Without strong and enduring partnerships with the health community, we will run the real risk of not reaching the National Strategy's youth targets for 1996.

The 1996 objectives include the following:

- . 88 per cent of all 15-19 year olds will not smoke;
- . 80 per cent of all minors will believe that tobacco use is not socially acceptable and that a substantial majority of adults do not smoke;
- . 70 per cent of all 10-14 year olds will know that tobacco is addictive, and
- . points of purchases of tobacco will be reduced by 30 per cent.

Tobacco, a toxic and addictive substance, is the only consumer product that is dangerous when used exactly as intended.

As a result, smoking continues to be the leading cause of premature, preventable death in Canada.

Our combined efforts in this field are vital; our preventive actions can determine both the quality and duration of the lives of our young people.

I hope each one of you has a strong sense of the importance of your own work. Mr. Létourneau, for instance, has demonstrated that fewer young persons smoke in urban Montreal and Quebec City, because educational and health programs to reduce tobacco use are more numerous or more accessible in cities than in rural areas.

These are precisely the kinds of programs with which most of you are involved.

I wish to compliment you on your forward-looking approach and the range of issues you will address at this special meeting.

All of us share the strong desire to do all we can to prevent young persons from getting hooked on cigarettes. Working together, we can have a significant impact on the health of young Canadians and the population in general.

Thank you for giving me an opportunity to speak to you today.





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# Speech / Discours

**Speaking notes for  
the Honourable Benoît Bouchard  
Minister of National Health and Welfare**

**Canada Committee for the  
1994 International Year of the Family  
Ottawa, November 24, 1992**



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Committee members, ladies and gentlemen.

Good afternoon.

It is with great pleasure that I welcome the founding members of the Canada Committee for the International Year of the Family.

They are: le juge Andrée Ruffo of the Youth Court in Montreal; Senator Nancy Teed of Saint John, New Brunswick; Mr. Robert Couchman of the Donner Canadian Foundation in Toronto and Mr. Aziz Khaki, President of the Committee for Racial Justice and of the Pacific Interfaith Citizenship Association of British Columbia.

Two other founding members, Ms. Ann Charter, Professor of Social Work at the University of Manitoba and Madame Ghyslaine Picard-Mayer of Montreal, President of Family: Horizons 1994 and of the Canadian Committee of the International Union of Family Organizations could not be with us because of prior commitments.

On behalf of all those present, I would like to congratulate the founding members and thank them for agreeing to establish the *Canada Committee for the International Year of the Family* as a non-profit organization which will plan, stimulate and support the participation of both the public and private sectors in activities for the International Year of the Family.

I would like to take this opportunity to remind all present of the United Nations stated objectives for the International Year of the Family "to stimulate local, national and international actions..." that value families for their enormous contribution to the welfare of our society.

It is therefore my hope that in 1994, Canadian families themselves will have an opportunity to join with the members of our international family in celebrating this important year.

I would like to see Canadians participate as actively as possible in the International Year of the Family, for I see the year as their celebration.

For its part, the federal government is contributing \$2.1 million over three years through the *Brighter Futures* program to support the *Canada Committee for the International Year of the Family*.

As well, we have set up a federal International Year of the Family Secretariat within my Department to work with the Canada Committee in promoting the International Year of the Family and to coordinate all federal initiatives with respect to the International Year of the Family.

For me, and I'm sure for others in this room, the key to a successful International Year of the Family will be the establishment and maintenance of close working partnerships among all the players: governments, non-government organizations, the private sector, professional associations, aboriginal communities and, most importantly, families themselves.

Many government departments will be active in these celebrations, building on a long history of policies and programs to assist Canadian families.

Most recently, I announced the *Brighter Futures* initiative to assist children and their families. It is a program targeted to help the over one million Canadian children at risk and their parents.

*Brighter Futures* is a four step program. The first involved the ratification of the Convention on the Rights of the Child. The second is the new Child Tax Benefit. A third step resulted in the publication of Canada's action plan for children.

The fourth and final step, the Child Development Initiative, is a 500 million multi-year program aimed at preventing and reducing conditions of risk among children.

Other federal efforts in support of families include the *Family Violence Initiative*, the *National Drug Strategy* and the Missing Children's Registry.

Work is in progress to develop a federal action plan to celebrate the International Year of the Family, an action plan that will build on existing programs and focus on a partnership approach. We believe that the importance of collaborative and complementary efforts cannot be overly emphasized.

On the provincial scene, some governments have started to plan for the International Year of the Family. For example, I know that in Quebec, Manitoba and Alberta they have started their preparations for the International Year of the Family.

Also, the non-government organizations community through Family: Horizon 1994 is actively working to ensure the success of the International Year of the Family.

In particular, I would like to see the private sector participate fully in the International Year of the Family celebrations and join the Canada Committee with active memberships. I know many businesses already support many family oriented programs and policies in their communities and I believe it is very important to bring these to the forefront.

I know that the *Canada Committee for the International Year of the Family* will work with us, the provinces, municipalities, non-government organizations and with Canadian families themselves to truly celebrate the role the family plays in society.

In agreeing to become founding members of the *Canada Committee for the International Year of the Family*, you have accepted a challenge. It is a most worthy one for which I wish you success and pledge the federal government's support.

Thank you.

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# Speech / Discours

**Speaking Notes for the  
Honourable Benoît Bouchard,  
Minister of National Health and Welfare**



**Breast Cancer Research Challenge Fund  
Toronto, December 15, 1992**

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Thank you Dr Jacques Cantin of the Canadian Cancer Society. And thank you all for coming.

This morning I am here to talk about a disease that in some way touches all Canadians. There are few among us who have not known someone with breast cancer -- a member of family, a co-worker, friend, mother, wife or daughter.

While I can never know the fear a woman feels when diagnosed with breast cancer, I can empathize with her anxiety, her anger and fear when faced with the consequences of breast cancer.

Currently in Canada, one in every ten women can expect to develop breast cancer at some time in her life. It is the leading cause of cancer deaths among women in this country.

This year alone, some 15,700 Canadian women learned that they had become a statistic. While 15,700 women were being diagnosed with breast cancer, another 5,200 lost their lives to the disease.

Those are frightening figures. And this is the reason I'm here to talk to you today. I am here to talk about ways we can fight this disease together.

Breast cancer strikes women in their prime when they are most active and have the greatest work and family responsibilities. Women make up over half of our population, 52%, and when they are at risk, all of society suffers.

Before I go any further I would like to take this opportunity to congratulate my colleague Barbara Greene, who is here with us today, and the members of the sub-committee on the Status of Women who brought this issue to the forefront of the government agenda with their thought provoking report entitled, *Breast Cancer: Unanswered Questions*.

The committee's thoughtful and compassionate study has not only helped the federal government focus on this illness but mobilized movement from grassroots committee groups. The federal government's response to this report has been deposited today in the House of Commons.

At this time, I am pleased to announce a series of new initiatives which I first promised in Parliament last June. At that time, when *Unanswered Questions* was released, members of the Opposition asked that the government allocate \$2 million to establish a Canadian Breast Cancer Fund.

At that time I replied that if there was any way we could find more money for breast cancer, we would. And we have.



The federal government recognizes that breast cancer is a national challenge and that research prevention and partnership initiatives are needed to help tackle this disease.

It is my great pleasure to report that the Government of Canada will allocate \$25 million over the next five years to face this national challenge.

Health and Welfare Canada together with the Medical Research Council will contribute \$20 million over five years, to establish a *Breast Cancer Research Challenge Fund*. This fund will be directed into the necessary areas of biomedical and psycho-social research.

We are calling it a *Challenge Fund* because we see the federal commitment as just the beginning of a broad-based *partnership* effort by all Canadians to help fight this deadly disease.

With this fund I am calling on the private sector, other governments and non-governmental organizations to contribute. Research is an investment in our people, an investment in our collective future.

Through the common goal of increased research for breast cancer we have the opportunity to build new partnerships and strengthen existing ones. And together we can have a stronger impact in the battle against breast cancer.

Members of the corporate community have already recognized breast cancer as a national priority. I would like to congratulate the Royal Bank of Canada for its recent commitment of \$500,000 to the cause of breast cancer research.

It is my sincere hope that other private sector partners will follow the lead of the Royal Bank in their generous donation. I would also like to note the contribution made by corporations involved with the *Look Good Feel Better* program.

There is no one way to prevent or treat the disease, but a variety of health practices need to be studied. For that reason, the federal government will co-host -- in collaboration with the National Cancer Institute of Canada and the Canadian Cancer Society - a *National Consensus Workshop* in 1993.

This workshop will help to define research and health services priorities, review the results of the national breast screening study and devise an agenda for action.

One of our aims is increasing the accessibility to state of the art information to health professionals, women and families, to help them make better informed decisions.



That is why we will contribute \$2.7 million over five years to fund five existing cancer centres or health care institutions to develop *Breast Cancer Information Exchange Projects*.

These projects, located within the five regions of Canada, will be selected in consultation with the provinces. It is a goal of each project centre to develop specific expertise to disseminate state of the art, user friendly information on various aspects of breast cancer.

The projects will have a strong evaluation component, with input from both health professionals and patients. They will serve as a model to be used by other cancer centres or health care institutions to disseminate, in a timely fashion, information to women, their families and health care professionals.

The results of this *one time* program will be shared at a national and regional level.

The federal government will also channel \$300,000 toward enhanced training and education programs for health professionals directly involved in the diagnosis and treatment of breast cancer.

We recognize that they, too, deserve special recognition and support for the sensitive work they do.

As part of our quality of care mandate, we will allocate \$300,000 to pull together an expert group to foster and develop uniform high standards of care for breast cancer across the country.

And, with a commitment of \$1.05 million over five years, we will continue to assist our provincial partners with the implementation and evaluation of ongoing provincial breast cancer screening programs.

It is essential that all of us encourage and support the work of our partners in the system.

I particularly want to point out the invaluable work of the National Cancer Institute of Canada, the Canadian Cancer Society and the many breast cancer support groups operating across the nation.

They have provided direct support to thousands of breast cancer patients.

We are calling on all the partners to help us build on the successes of the existing systems and organizations, to continue to wage a battle against breast cancer. We know we work best when we work together.

Whether we are in government, the health professions, cancer research or treatment institutes, voluntary organizations or survivor support networks, we all have vital roles to perform.

I would like, especially, to acknowledge the important advice that survivor groups have to offer. They, more than anyone, understand the urgency of the situation. At the same time, they can provide the sensitivity to ensure our responses are appropriate.

It is precisely why we are inviting surviving breast cancer patients to participate in research and policy development. Working alongside professionals, they will be members of the management committee responsible for setting research directions in the *Research Challenge Fund*.

As well, they will be partners on the advisory committee and participate in the selection of the five regional centres which will operate the information exchange projects.

They believe, as do I, that we must offer our mothers, our sisters and our daughters with breast cancer the very best -- whether in the fields of research, bio-medical or psycho-social advances.

I encourage you to join us as we move forward and put this plan into action.

I believe this series of new initiatives is just the beginning of much better things to come.

It is my hope that as the new year unfolds, we will see more corporate and private donors come forward with contributions to the *Breast Cancer Research Challenge Fund*.

I am looking forward to seeing the five regional Exchange Projects up and running, so women and their families can have increased access to the best available advice and information.

Every one of us, from every segment of society, has a part to play. Breast cancer is a national priority that deserves our dollars, our determination and our dedication if we are to make progress.

Pulling together and working in partnerships, we can and will find long-term solutions to one of this country's most pressing health problems.

Thank you.

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# Speech / Discours

Speaking Notes  
for Benoît Bouchard  
Minister of National Health and Welfare

Launch of Break-Free All Stars  
Toronto, March 10, 1993

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Ladies and Gentlemen, Good afternoon.

It is a privilege for me to help launch **Break-Free All Stars**, a national smoking prevention program for children.

I am honoured to be here with representatives of our major partners for this program -- Mr. Pirk and Mr. Skripitsky.

Your partnership is invaluable. Each of your organizations plays a vital part in making this new program happen.

I also want to take this opportunity to complement June Rowlands, the mayor of Toronto, on her city's clean air bylaw which now prohibits smoking in private as well as government offices and in public spaces such as sports facilities, theatres and shopping malls.

Our number one public health problem in Canada today, by far, is smoking. Tobacco use is **the** leading preventable cause of early death among Canadians.

Virtually all new users of tobacco products are children and teenagers. At least 70,000 Canadians under the age of 19 start to smoke each year.

In addition, children now start smoking as early as age 12, compared to age 16 about a generation ago.

My department is tackling this problem head-on with a variety of partnership initiatives aimed at reducing tobacco use.

These efforts are part of the **National Strategy to Reduce Tobacco Use in Canada**.

The main goals of the **Strategy**, which involves all levels of government as well as the major national health organizations, are to help non-smokers stay smoke-free, to help smokers who want to break the habit, and to protect non-smokers from the health hazards of second-hand smoke.

**Break-Free All Stars**, a bilingual program, is a key initiative in this strategy.

Our goal is to promote non-smoking as a positive and desirable behaviour to children while they are young -- between the ages of eight and ten. There are about one million Canadian children in this age group.

It is vital to convey this information early, before children are tempted to try smoking.



Participating partners have worked together to develop, deliver and fund this pioneering program which is based on principles of active living and smoking prevention.

Active living means valuing physical activity and making it part of everyday life. It is important for children to learn that smoking and active living don't mix.

**Break-Free All Stars** consists of warm-up exercises, games and quizzes played in the recreation settings children love, with the recreation leaders they admire -- many of whom are with us today.

Recreation leaders will be provided with kits and are invited to incorporate Break-Free All Star exercises or games into existing programs offered by community parks and recreation departments, Boys and Girl Clubs, YWCAs and others.

Games make kids feel good about themselves; they help them develop confidence and decision-making abilities.

**Break-Free All Stars** games are designed so that recreation leaders can help children realize that they will feel better and play more energetically if they choose to remain smoke-free.

Kids need to know that most people don't smoke and many find it unattractive because fitting in means so much to them.

The "**All Stars**" are the youngsters themselves. Being an All Star means being the best you can be in whatever you do. Looking after one's body, so it can give you its best, is an important part of being an All Star.

The "**Break-Free**" component of the name encourages kids to "break free" from old myths about smoking, to take control of their lives and to make their own healthy choices. We want to enhance their self-esteem, so that they can resist peer pressure and say "no" to cigarettes.

Let me give you an example of how a physical activity can be linked to decision making. In a nearby room, which we will visit soon, a group of children are playing Break-Free All Stars games for the first time.

In one activity, shoulder-tag, girls and boys circle and protect someone who is being chased. The game demonstrates the power of friends in keeping us safe from harm. Recreation leaders can use the tag game to explain how sticking to the decision not to smoke sometimes means finding the right supportive friends.



Another exercise involves skipping while reciting a **Break-Free** rap chant or improvised rhymes on fitness and self-confidence themes. Accompanying notes encourage the instructor to explain that jumping rope strengthens heart muscles and produces a feeling of well being.

Smoking, on the other hand, does the opposite. The chemicals in tobacco pollute the heart muscle and make it difficult for the heart to work effectively.

Rigorous testing in focus groups and a national pilot involving municipal recreation departments across the country demonstrated the effectiveness of **Break-Free All Stars**. Children enjoy the games and learn the smoke-free tips. Recreation leaders found the materials easy to use and to obtain.

**Break-Free All Stars** has the strong support of Fitness Canada, the Active Living Alliance for Children and Youth, and the provincial and territorial health and recreation ministries.

The development of a nation-wide program such as **Break-Free All Stars** is one of many important initiatives in the comprehensive effort to reduce tobacco use in Canada.

The seven strategic directions of the **National Strategy to Reduce Tobacco Use in Canada** include: legislation, information, services and programs, message promotion, support for citizen action, policy co-ordination and research.

This **Strategy** is a good example of the type of prevention program being developed by the federal government. I strongly believe that we must focus our attention on prevention rather than remedial action.

The success we have had in various other programs such as the **Driving While Impaired Initiative** and **Canada's Drug Strategy** shows that prevention **can** work and that our children are one of the best places to start.

I want to extend my thanks again to our major partners -- the Canadian Parks/Recreation Association and Parke-Davis Canada -- for their invaluable contributions.

In closing, I want to thank the recreation leaders of the city of Toronto for testing the **Break-Free All Stars** program and I want to emphasize to everyone the importance of recreation leaders -- the children's role models -- in this program.

Regardless of our age, we can all make decisions to improve our health. Young people can choose not to smoke. They can speak to friends who may be experimenting with cigarettes. Recreation leaders can promote the benefits of active living. We can all contribute to a healthy Canada.

Thank you for giving me an opportunity to speak to you today and I invite you all to join me in the gym to watch children participate in the **Break-Free All Stars** games and perhaps even to join them.

Thank you.



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# Speech / Discours

Speaking notes  
for Benoît Bouchard  
Minister of National Health and Welfare

National Aids Strategy Renewal Announcement  
Ottawa, March 11, 1993

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10/93

Canada



Good afternoon.

I am pleased today to announce the renewal of the **National AIDS Strategy**.

The goals of the renewed strategy remain the same --

- ◆ to stop the transmission of HIV,
- ◆ to search for effective vaccines, drugs and therapies, and,
- ◆ to care, treat and support people infected with HIV, their caregivers, families and friends.

Building on the progress and partnerships developed in Phase I of the **Strategy**, Phase II will emphasize five strategic policy directions:

- ◆ enhancing partnerships, improving health promotion for people living with HIV/AIDS,
- ◆ creating supportive social environments,
- ◆ promoting and sustaining healthy behaviours, and
- ◆ recognizing HIV disease as a chronic and progressive condition.

It also emphasizes financial accountability and enhanced program evaluation.

Renewal of the five-year strategy at a time of serious economic restraint demonstrates the federal government's commitment to meeting the challenges of HIV/AIDS.

Funding for the **National AIDS Strategy** will total \$ 42.2 million annually or \$ 211 million over the next five years.

This represents a significant increase over Phase I which was \$37.3 million annually.

At a time when federal departments are being asked to reduce programs, this investment is indicative of the federal government's commitment to find a cure to this fully preventable, communicable disease which has reached epidemic proportions.

Funds under Phase II of the **National AIDS Strategy** will be allocated among five key areas:

- ◆ \$ 6.2 million for prevention education;
- ◆ \$ 17.8 million for research;
- ◆ \$ 9.8 million for community development and support for national non-governmental organizations;
- ◆ \$ 5.4 million for care, treatment and support; and finally,
- ◆ \$ 1.5 million for co-ordination and collaboration.

I have also asked my Deputy Minister to allocate an additional \$ 1.5 million annually from within my department for AIDS-related initiatives.

As well, the Medical Research Council is committed to supporting AIDS research at \$ 2 million per year over the next five years. Since 1983, the Medical Research Council has devoted more than \$ 13 million towards research and training in AIDS.

The challenge of HIV/AIDS must be a concern for all Canadians. The fact is that each and everyone of us is living with the AIDS reality.

I call upon all Canadians to work in partnership with governments, community groups, researchers, health and social service professionals and the private sector.

We need everyone's involvement. In particular, all partners should work with the private sector to mobilize assistance in order to help achieve our goal.

In closing, I would like to say that I believe that the **National AIDS Strategy** reflects this government's commitment to sound social policy and to a healthy Canada.

AIDS is a problem that we all must address. It has significant implications for public health, human rights, and costs to our economy and health and social service systems.

Within this context, collective efforts by governments, organizations and individuals are essential if we are to achieve our aim of eliminating this devastating disease.

I look forward to the day when a Minister of Health somewhere in the world stands up to announce that the AIDS epidemic is over.

Thank you.





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# Speech / Discours

Speaking Notes  
for Benoît Bouchard  
Minister of National Health and Welfare  
and Minister Responsible for the Federal Office  
of Regional Development - Quebec

National Native Suicide Prevention Conference  
Ottawa, March 22, 1993



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Good morning, welcome, and thank you for coming together today.

I know that many of you have travelled great distances, and that some of you have left behind crisis or near-crisis situations, to be here today.

I am grateful that you have taken the time to come to share your experiences, your knowledge and your insight into the suicide crisis in your communities.

It is an indication of hope. A hope, I believe we share, that this dreadful and recurring trend of suicide can be reversed. We know that it *must* be reversed and that none of us alone can find a quick solution.

There are many reasons why a quick fix can't be found: the depth of the problem, the diversity of conditions of risk, and the number of partners involved. But some of these reasons are also reasons for hope; there are many who want to be involved, to find answers.

The diversity of risks allows us the freedom to find a diversity of solutions, the freedom to look for different answers to different problems.

Suicide can have many causes: poverty, unemployment, ill health, abuse of all kinds and historical injustices to name only a few.

Mistakes were made in the past. My government has begun to look at these and we must examine these problems together so that we can learn lessons which will help us all in the future.

Even listing these causes illustrates why there are no easy solutions and why one partner can't do it alone.

I and my department have brought so many of you together because we know that you will work, not only to identify short-term solutions, but, as well, a long-term vision -- a vision developed by First Nation and Inuit communities for your own communities.

We have seen too many times that government-imposed solutions do not work in Aboriginal communities. Governments should be involved and there are many roles for government to play -- from facilitator, to partner -- but not as leader. In your communities, you must assume that role.

In many of my discussions with Aboriginal communities over the past few years, I have heard you express major concerns about the mental health of children, adults and families. And you have indicated that the solutions must be holistic and must be long-term.

The objective of this workshop, as you know, is to bring together Indian and Inuit people from across Canada to explore options for suicide prevention. I know that some of you already have suicide prevention programs in your communities, and that this will naturally include mental health issues.

Some of those programs will be featured in plenary and workshop sessions over the next three days.

This workshop is a follow-up to a meeting I had in December with 11 Aboriginal leaders and community care workers.

I heard first-hand accounts of the tragedy, pain and suffering that surround the hopelessness and emptiness of suicide. And I know that those accounts could be repeated by many of you. I want you to know that my commitment has not diminished in the past three months.

Recent events have only strengthened it.

I want to work with you -- with your communities -- to ensure that the expenditure of federal dollars in this area achieves what it is intended to do. And that is to save as many lives, and to offer as much hope for the future, as humanly possible.

While we must continue to work on crisis management and carry on working with those who are in trouble, I believe that our primary focus must remain on prevention. For it is only by working to prevent problems, that we can offer full hope for the future.

My department has already accomplished some important work in this area.

Since 1982, the **National Native Alcohol and Drug Abuse Program** has been addressing challenges related to alcohol, drug and inhalant abuse.

In many communities, these problems are linked directly to the ongoing tragedy of suicide. This program has supported about 380 community-based prevention projects this year, as well as 51 native treatment centres across the country.

Since 1990, we have been working with the Department of Indian Affairs and Northern Development and Aboriginal communities to deliver the Indian and Inuit component of the family violence and child sexual abuse initiative.

These abuses may reach directly to the heart of the problem in many communities.

By designing various programs the government is working with communities to help eradicate abuse not only on reserves, but for society as a whole.

As I stated earlier, we obviously cannot ignore the crisis situations that are happening all too often.

I have attempted to address these incidents to the best of my ability with the resources that are available. In the case of Davis Inlet, my department immediately undertook to transport the affected Innu children to treatment facilities identified by the community.

This was our first priority and concern -- to help those children get treatment quickly. In the longer-term, we are working with Innu leaders and the provincial government to establish community-based intervention programs that focus on youth and their families.

I am determined to provide the support I can to reverse the situation of alcohol and substance abuse.

In late February, I also agreed to provide additional support to the people of Big Cove in New Brunswick, to address the frightening epidemic of teenage suicide in that community. I was approached by community leaders who, following a coroner's inquest, had prepared a proposal for a suicide prevention initiative, and I accepted that proposal in its entirety.

This new community-based initiative is over and above the support being provided to Big Cove under the **National Native Alcohol and Drug Abuse Program** and other health related services.

The response at Big Cove and recent actions taken by the leadership to limit alcohol on the reserve, hold their own study and galvanize community support, show how well a community can respond when all partners work together.

Only time will tell, but I am confident that we are on the right path. We need to explore together ways to co-ordinate existing resources to address these related issues.

These kinds of responses to crisis situations *are necessary* to avoid the worst possible outcome. In the longer term, however, I believe that we have to improve the mental health of individuals and entire communities in order to *prevent* suicides.

This was confirmed by Indian and Inuit participants at our December meeting along with the focus on prevention, especially for the very young.



I believe the **Brighter Futures** initiative, the government's initiative for children, is *one* concrete vehicle for achieving this goal.

As you know, a specific component of **Brighter Futures** has been targeted for Indian and Inuit communities, based on extensive consultations with Aboriginal leaders.

Its objective is to help communities -- your communities -- address issues related to the mental, physical, emotional and spiritual well-being of children and their families.

A total of \$176.4 million will be provided over five years for this program component. The bulk of this funding -- \$145 million -- will be spent under the **Community Mental Health/Child Development Program**.

This funding is helping Indian and Inuit communities develop their own comprehensive, community-based mental health programs to address such problems as family violence and child development issues including high rates of youth suicide.

Fifteen million dollars has been earmarked to address solvent abuse, which also has a clear link to suicide.

Funding for the **Community Mental Health/Child Development Program** will rise over the five-year period, from \$8.5 million in 1991-92 to \$66.5 million in 1995-96 and future years.

This will give communities an opportunity to plan properly and prepare for the mental health programs, a process that is already under way in many communities.

In today's world of scarce financial resources, it is vital that we co-ordinate our efforts in order to achieve solid results. And that means we must work together.

**Brighter Futures** involves Indian and Inuit leaders and government and non-governmental associations in a full and dynamic partnership.

Together, our challenge will be to co-ordinate and to use program resources in the context of a community plan: developing and implementing new ways to address the mental and physical health needs of children, learning more about the causes of suicide, and the effectiveness of prevention and treatment strategies; continuing to support holistic activities that are controlled and implemented by community members and developing models of community-based mental health activities that are flexible, viable and effective.



I know that some First Nation and Inuit communities are well into the strategic planning phase of their community mental health programs. Still others have begun developmental activities.

I want to assure you of my ongoing support, and the support of my department, as we work towards the eventual implementation of full-fledged programs.

I also want to inform you of a number of steps that my department has undertaken in order to facilitate your community work under **Brighter Futures**.

A survey of Aboriginal communities will be undertaken to determine the extent of solvent abuse. It is crucial that we know the numbers, that we know the extent of the problem and identify the areas that are hardest hit in order to properly address these issues.

Funding was provided to the Ojibway Tribal Family Services in Kenora to produce a video on teenage suicide prevention, which I understand will be screened at this workshop.

A manual is also being produced that will help First Nation and Inuit communities evaluate how their existing mental health and child development programs are working.

We have supported the development of an activity book for pre-schoolers by the First Nation Education Council in Quebec, a booklet that eventually will be available across Canada. The activity book highlights situations which demonstrate the importance of health, well-being, self-esteem, education, parent-child relationships and respect for elders and culture.

But **Brighter Futures**, indeed any government program, cannot solve all problems. I believe the three days you will spend together will contribute immensely to the development of community-based holistic programs.

And I believe it will help us set some long-term objectives and strategies for both Aboriginal people and for governments.

These long-term strategies and objectives, a long-term vision, are vital to the success of our interventions, both direct and preventative.

I truly believe that by working together, by working with a range of community-based and community-paced solutions, and by sharing information, expertise and hope, we can eliminate these tragic suicides.

I have asked my department to work closely with you, to listen to your needs and your suggestions and I look forward to hearing the results. The current situation must change. Children need to look forward to a better tomorrow. Together, we are taking the first steps.

Thank you and good luck.

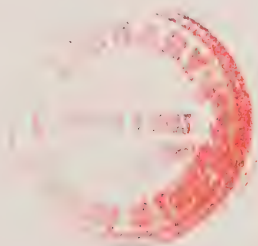


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# Speech / Discours

**Speaking Notes  
for Benoît Bouchard  
Minister of National Health and Welfare  
and Minister Responsible for the Federal Office of  
Regional Development - Quebec**



**News Conference:  
Tobacco Products Control Regulations  
Ottawa, March 19, 1993**

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Ladies and gentlemen, I am pleased to announce that the *National Strategy to Reduce Tobacco Use* today takes another step forward in the field of prevention.

New proposals for changes to the regulations made under the *Tobacco Products Control Act* will be published today in the *Canada Gazette Part I*.

In 1990, my predecessor proposed that amendments be made to the *Tobacco Products Control Regulations*.

These amendments included revised health warning messages, toxic constituent information, and package leaflets.

Before the amendments could be introduced, the Quebec Superior Court declared the *Tobacco Products Control Act* unconstitutional, as contrary to the Charter and not within the jurisdiction of the Federal Government.

As a result, the regulatory amendments were put on hold until the Quebec Court of Appeal ruled on the constitutionality of the Act.

In January of this year, the Quebec Court of Appeal overruled the lower court decision and found the *Tobacco Products Control Act* to be within the jurisdiction of the Federal Government and in compliance with the Charter. Consequently, proceeding with amendments to the tobacco regulations resumed.

It is my wish to proceed with these regulatory amendments as quickly as possible. Consequently, the original package proposed in 1990 has been revised and improved taking into account comments received after initial publication, as well as new advances in health promotion.

With the new amendments to the *Tobacco Products Control Regulations*, it is expected that Canadians' awareness of the health hazards associated with smoking will improve significantly.

These amendments are an essential part of the *National Strategy to Reduce Tobacco Use* in Canada.

The main goals of the strategy are:

- to help non-smokers stay smoke-free;
- to help smokers who want to quit to do so; and
- to protect non-smokers from the health hazards of second-hand smoke.

These goals are being implemented using legislation, education and promotion.

This government has made unprecedented progress since January of this year in our efforts to curb the use of tobacco.

I introduced the *Sale of Tobacco to Young Persons Act* in February of this year and it will receive royal assent very shortly.

Earlier this month, I announced the creation of *Break-Free All Stars*, a national program aimed at reducing tobacco use among youth.

And the government's efforts will not end there. Next month, I plan to announce a new program designed to help teenagers quit smoking.

As well, this government recognizes the severe problem of tobacco smuggling in Canada.

I have met recently with my cabinet colleagues and we expect to be in a position to announce shortly new measures to curb this illegal and highly destructive practice.

The changes in labelling, as outlined in the new regulatory proposal, will provide better information to consumers about the serious health hazards of using tobacco products.

The amendments will require new health messages to appear on cartons and packages of cigarettes and cigarette tobacco, effective September 1, 1993.

These stronger messages will:

- be prominently displayed alternatively black on white and white on black;
- located on the top edge of the package; and
- outlined by a border of 3 to 4 millimetres in thickness.

The messages will occupy an area not less than 25 per cent of the principal display surface.

The improved health message to appear on cigarette cartons will be "Smoking causes lung cancer, emphysema and heart disease."

Information leaflets describing health effects of tobacco products were proposed to be inserted inside the tobacco packages, as outlined in Information Letter 776, in 1990. They will not be included in these new amendments. More information is needed to determine their effectiveness.



My departmental officials will evaluate messages on inserts against alternative ways of providing the information to determine what is feasible, appropriate and, most importantly, which format would most effectively convey the greatest amount of information on the hazards of tobacco use.

This evaluation will involve detailed focus group testing and communications studies. I have requested that the Department report back to me by September 1, 1993.

I will now answer your questions.





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# Speech / Discours

Speaking Notes  
for Benoît Bouchard  
Minister of National Health and Welfare  
and Minister Responsible for the Federal Office  
of Regional Development - Quebec



Launch of **Quit 4 Life** Program  
Montreal/Toronto, April 6, 1993

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18/93



Ladies and gentlemen,

It gives me great pleasure to take part in the launch of **Quit 4 Life**, a national smoking cessation program for teenage smokers.

It is a privilege to be here with representatives from two organizations that helped make this much-needed program a reality -- the Lung Association and Ciba-Geigy.

**Quit 4 Life**, the first national teen quit-smoking program in Canada, is an important part of **National Strategy to Reduce Tobacco Use** in Canada.

The **Strategy** is a joint effort by all levels of government, health organizations and concerned individuals to achieve the goals of prevention, protection and cessation of tobacco use.

**Quit 4 Life** is the final component in the unprecedented series of initiatives undertaken by the federal government in the past three months to curb the use of tobacco products by young persons:

- ◆ passage of the *Tobacco Sales to Young Persons Act*, which became law in March. Effective next spring, it will be illegal for persons under the age of 18 to buy tobacco products. As well, retailers convicted of selling tobacco products to minors will face stiff fines;
- ◆ the launch of **Break-Free All Stars**, a national healthy living program that strives to reduce tobacco use among young children;
- ◆ changes in tobacco product labelling, which I announced on March 19. I expect that when the new health warnings appear on packages of tobacco products in September, they will provide Canadians with the information they need to make healthy lifestyle choices.

Tobacco use is the leading preventable cause of early death among Canadians.

Although the number of smokers in Canada continues to drop, an alarmingly high number of teenagers ages 15 to 19 smoke -- as many as 25% of young women and 19% of young men.

Experts in smoking cessation programs helped my department put together **Quit 4 Life**. The self-help program is for teenagers between the ages of 15 and 19 who smoke regularly and want to quit.

The program invites the teenage smoker to embark on a voyage towards a tobacco-free life -- a destination that offers a sense of well-being, better health and a healthier bank account.

Realistically, the program urges teens to view relapses as a stopping place on the trip to the final destination -- freedom from cigarettes.

I have a teenage friend who set out last year to achieve her goal of not smoking by promising herself a dream gift -- a concert hall-quality stereo system -- if she succeeded.

She did. She calculated that her reward cost her the equivalent of a year's worth of cigarettes.

**Quit 4 Life** encourages the same approach. The kit includes an intriguing, hand-sized "wheel of benefits" which rotates to display items teens can purchase with money that is saved instead of spent on buying a package of cigarettes a day.

**Quit 4 Life** kits will be promoted through the media, in schools, doctors' offices, pharmacies, and by Lung Associations and health professionals across the country.

Teen smokers can order free kits, in either French or English, by calling 1-800-363-3537.

Again, I want to acknowledge the valuable contributions of our partners -- Ciba-Geigy and the Lung Association.

Working together, we can have a significant impact on the health of young Canadians. Working together, we can build a healthy Canada for all of us.

**Quit 4 Life** is a tool that will help achieve this goal. I hope you use it, because I know that if you really want to quit, with the help of this kit, you can do it.

Thank you.





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# Speech / Discours

**Speaking notes  
for Benoît Bouchard  
Minister of National Health and Welfare  
and Minister Responsible for  
the Federal Office of Regional Development - Quebec**

**The 46th World Health Assembly  
Geneva, May 4, 1993**



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23/93



Mr President, Dr Nakajima, fellow delegates, ladies and gentlemen,

Few among us today would dispute the fact that the world health organization finds itself at a crossroad in its history. It is therefore not surprising that the Director-General has asked us to give special attention to **health development in a changing world** during our debate in plenary.

Mr President, there is no question that for the better part of half a century the World Health Organization (WHO) has been at the centre of global health development, contributing significantly to the betterment of humanity.

Indeed, the World Health Organization occupies an enviable and privileged place in the young history of many developing countries. But the world is changing at an increasing pace.

WHO's own history has been characterized by change, as much in its membership as in programme content and orientation. For example, in July 1948, when the first world health assembly divided the world into six regions, only three countries of the African region had endorsed the constitution (Ethiopia, Liberia, South Africa).

Only some ten years later, in the wake of decolonization, did the next country, Ghana, join the organization. In the Americas, almost all the countries of the Caribbean joined WHO only fifteen years after its creation. More recently, the winds of independence in central and eastern Europe are markedly altering the composition of the organization.

Since its creation as the directing and coordinating authority in international health, WHO has had to remain at the leading edge of health sciences in a world of increasing technological advances and complexity.

The executive board has asked the question "how is WHO doing in a rapidly changing world". Perhaps the real question is "how can we strengthen WHO's capacity to help its member states respond to change". For there is no doubt that all countries of the world are experiencing changes that are profoundly affecting their health sector.

Mr President, for more than twenty years, Canadians have enjoyed a health care system that has provided universally accessible hospital and medical care. We are proud of the system we have developed. Our medicare system is our most valued social program.

Still, during the last several years a number of stresses and strains on the system have emerged. The cost of our system is becoming a major concern. Canada is a heavy spender on health: the Organization for Economic Co-operation and Development (OECD) ranks us number two among member countries in terms of health expenditures as a percentage of GDP.

This has made us to look closely at our system -- to review it with the goal of ensuring that it continues to serve all Canadians well in a cost effective and efficient manner.

We have therefore begun the process of readjusting our health system. All of our provincial governments, which are responsible for the management and operations of the health system, have formulated strategic plans for reform. Some have made significant progress in implementing these plans which will both improve the health of Canadians, maintain a high quality of care, and at the same time control cost factors.

As a priority the Canadian system has begun to change its focus. We must move from a health care system, where the emphasis is on curative and treatment services, to a health system, where the emphasis is on population health. This change will result in increased integration of disease prevention and health promotion within the entire spectrum of social programs.

Increasingly we recognize that there are many determinants of health beyond health care. Health is affected by a variety of factors. An individual's genetic background, education, socio-economic conditions, and the environment in which we live and work all have an effect.

Canadians are firm believers that health gains can continue to be made if we redirect our health care system towards community-based care alternatives.

We need to promote greater accountability within the system, to improve health outcomes and to ensure good value for our tax dollars.

Another challenge for our health system is population aging.

We must plan for the future to ensure that the health system is prepared to respond to the changing health needs of an increasingly older population, by making sure that the care we deliver is appropriate.

We must better manage the use of technology, ensure its effectiveness and provide for its distribution in an equitable manner which best responds to the needs of the population.

Effectiveness and efficiency must be foremost considerations for all health stakeholders. An important component of this policy is enhanced cooperation between governments, health providers and consumers. A partnership among all parties is necessary to ensure that the goals of quality care and cost-effectiveness are achieved.



We must also recognize and deal with the challenge of public expectations of the health system. This can be a formidable task. We know we have enough resources to meet patients' needs, but no amount of health spending would be sufficient to satisfy all consumers' wants.

The public, and providers as well, must be provided with the information necessary to make informed choices about what is reasonable and what is appropriate care.

A great deal of progress has also been made on a nation-wide basis in developing and implementing strategies regarding disease prevention and health promotion.

We are pursuing active national strategies to reduce tobacco use, to reduce the harmful effects of drugs, to address issues related to health and the environment, to stop the spread of HIV infection and AIDS, and to ensure the health and well-being of our children.

These are some of the challenges facing Canada's health system at this time.

The Canadian system is based upon the principles of accessibility and universality. It is administered by the provinces and territories and characterized by public financing and by decentralized management.

Mr President, the pace of reform has also increased in recent years within the United Nations system as a whole, partly as a result of global reconfiguration, and because the UN is now nearly fifty years old and must show a maturity in its development that befits its age. These reform efforts will have a significant influence on social development.

In the pursuit of overall efficiency within the United Nations system, there is a need to ensure that each agency builds on its comparative advantages and complements the work of the UN system as a whole. This vision of complementarity can only succeed through close coordination, especially at country level.

The Secretary-General of the United Nations must be commended for his actions to improve coordination of humanitarian assistance, to strengthen inter-agency collaboration and to ensure the effective implementation of Agenda 21, as recommended by the UN conference on the environment and development.

In closing, Mr President, I would like to reaffirm that all countries need to reconsider their health systems. Economic, demographic and epidemiological changes have occurred at a pace which has rendered obsolete health systems oriented to the provision of facility-based curative services.

All countries can and should benefit from health reform. With concern for the quality and sustainability of its system, Canada has given priority to health reform. We wish to learn from others and to share our own experience.

WHO belongs to us all and remains a unique instrument of consensus, collaboration and technical excellence. It is our duty to ensure that we make optimal use of this collective asset.

Thank you, Mr President.





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# Speech / Discours

**Speaking Notes  
for Benoît Bouchard  
Minister of National Health and Welfare  
and Minister Responsible for the  
Federal Office of Regional Development - Quebec**

**Healthy Canada  
Ottawa, May 12, 1993**



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24/93



Thank you.

It is a pleasure to be here today on the occasion of Canada Health Day. I would like to thank Gerald Dafoe of the Canadian Public Health Association and Carol Clemenhagen of the Canadian Hospital Association for their hard work in promoting Canada Health Day and, in particular, this event.

This is also Florence Nightingale's birthday, and International Nurses Day. The Canadian Nurses Association has done an admirable job in promoting National Nursing Week around this date and I would like to thank them as well for their efforts.

The theme for Canada Health Day this year is "Caring about health: everyone's responsibility". That is what I want to talk to you about -- my belief that health is a shared benefit as well as a shared responsibility.

Today is possibly my last opportunity as Minister of Health to talk about health. The health care system that we all cherish as Canadians is part of what I want to talk about, but only one part.

It is the aspect that gets discussed the most. In alarming headlines. Among concerned health professionals. And even during a leadership campaign.

I believe that informed public debate is necessary if our health care system is to meet today's realities -- so that it will be there to help us and our loved ones when we need it.

But I think it's important to differentiate between the health **care** system, which is the focus of most debate, and the health **system**.

The health care system isn't really about health at all. It is about intervention. In fact, it is an illness care system.

Today I want to urge Canadians to think about their own health, and that of their families and friends. I want Canadians to talk about health and, most importantly, to take action.

We know that we live in a time when our population is aging. In less than 25 years, the baby boomer generation will reach what we know as the retirement age. We also know that a population that lives longer tends to place more pressures on the health care systems.

I believe that unless individual Canadians begin to take action now -- action to ensure themselves of a healthier old age -- our health care system will not be able to meet the challenge.

Canadians must begin now to think seriously about sustaining good health longer. Canadians must recognize that although the personal rewards are many, the benefits in doing this are more than personal.

A healthier population will help us to afford our expensive health care system. It will help to ensure that it is there to intervene when you or someone you know needs it.

In addition, our national prosperity depends on a healthy, self-confident population which is first ensured of a healthy and reliable health system.

Through that system, we can provide vaccines to our population to protect them against chronic and acute diseases. We're far ahead of most other countries in this.

We teach our children about proper nutrition in our schools. We dispense all kinds of information to promote health and prevent illness.

These are among our most important building blocks for better health. It is part of the reason we are living longer than ever before, part of the reason we now have healthier babies. Indeed, many diseases have virtually disappeared.

However, I believe that as individuals, we must all be responsible for our own health.

I'm sure there is not a person here who has not been touched in some way when someone close to them or someone they know has been affected by a health problem. It is especially tragic when the problem occurs at a relatively young age and you know that steps could have been taken to prevent the problem.

I feel very passionately about this, because I am a living example of the interdependence between personal health decisions and the consequences of them. And the only reason I am a living example instead of a statistic is because the system intervened to give me a second chance.

Five years ago, I had open-heart surgery. I am alive today because we have an excellent record for heart health intervention in Canada -- deaths from heart disease have fallen 25% in 20 years.

But I now know that I could have prevented the problem. I was a heavy smoker, I didn't eat properly, I didn't exercise. These were all conscious decisions I was making. If I didn't think about them very much, whose fault was it but my own? And who was I hurting, but myself?

Well, I now realize I was hurting many people. Not the least of which was my family. The anguish of my situation was very hard on them. And the cost to the system was very high.

Obviously, I do not begrudge that cost, nor does my family, or my friends. I'm very grateful to be here today. And very anxious to share the lesson of my experience.

Today, I don't smoke. I eat better. I'm involved in healthy activities and exercise, although perhaps I could use a little bit more!

This experience makes the issues I deal with on a day to day basis as Minister of Health much more personal to me. In that context, I often think of how much better it would have been for everyone, not just me, if I had had the kind of discipline earlier in my life that I have now.

Perhaps "discipline" is not even the right word, because it makes it sound as if I am doing something very remarkable or very difficult. In fact, it is all a question of will and a question of healthy choices.

What does it mean to be healthy?

The World Health Organization has defined health not just as the absence of disease; but as something much more positive -- a complete state of physical, mental and emotional well-being.

In everyday terms, health is feeling good about ourselves -- both individually and collectively -- and feeling in control of what happens to us.

In fact, good health hinges on many factors. As individuals, we must learn how to stay well, and if we do become ill, we should have some understanding of the costs and benefits of different treatment options.

Health involves having the social support of families and friends, and living in a safe and clean environment -- one in which healthy choices are encouraged, and even made easier.

It includes having the capacity and skills to cope with disabilities and setbacks, and feeling satisfied with our accomplishments, and our lives as a whole.

Our broadened understanding of health requires a greater emphasis on disease prevention, health protection, health promotion, risk management, and support for those who cannot be self-sufficient. By putting more resources into these areas, we will be retooling our health system to meet the challenges of the 21st century.



One of those challenges is an aging population. Canadians must be able to rely on the system when they need it.

AIDS is another challenge. Unknown 15 years ago, it has reached epidemic proportions. And other diseases, long thought to be conquered, such as tuberculosis, are reappearing in more virulent forms.

New technologies also present a challenge. These often carry a high price tag.

Canadians needing health care while in the United States have told me of their shock when they came face to face with the price-tag for coronary artery by-pass surgery, kidney dialysis or magnetic resonance imaging -- services they would receive without charge in Canada, even if visiting another province.

Canadians expect access to the latest medical technologies. Yet, according to one study, up to 70% of these technologies have not been properly evaluated for cost-effectiveness. They *may* work, but perhaps they are not giving Canadians the best value for their dollar.

Other research suggests that as much as 30% of health care procedures in this country is either inappropriate or ineffective.

To compound the problem, Canada may well have an over-supply of physicians -- the growth in their numbers has been three times that of population growth since the mid-1960s.

These are some of the reasons, why as practical people, many Canadians have begun asking themselves some tough questions. Is our spending justified, given the returns? Are we paying enough attention to other alternatives?

Canadians want value for money and they want their standards maintained. And they also want care that is appropriate to their needs.

This is what the debate over the health care system is about: creating a balance between universality of services and the control of costs. There is danger in taking short cuts, in being tempted by immediate and easy solutions. User fees or taxing health services is not the answer.

I share the belief that there are sufficient resources within the health system and that, as a society, we need to review our system closely to ensure that it continues to serve all Canadians well in a cost effective and efficient manner.



But, by taxing disease we make health care less accessible for the less fortunate, and we can no longer ensure availability.

People who seek the assistance of health professionals do so because they believe they are sick and they are not qualified to self-diagnose their illness. If we limit access to health services will these people automatically be less sick? If there is abuse of the system, is it up to them to recognize it? Would we really consider that there is no more abuse because a \$5 user fee has been paid.

Imposing user fees restricts accessibility and creates two health care systems -- one for the privileged and another for the less fortunate. Nothing can convince me that this is a good choice. I prefer to ask you the following question.

Do Canadians actively and voluntarily abuse the health care system? Remember that the patient cannot judge whether he or she is really ill, cannot prescribe medication and rarely enjoys hospitalization for any length of time. Could it be that we simply refuse to admit that the debate must continue and that we must ask ourselves the difficult questions.

Canadians must be assured that the fundamental principles of their health system, as set out in the *Canada Health Act*, will be defended and protected as the cornerstone of a renewed federal-provincial partnership. It will be a challenge to future health ministers and governments to find ways to deal with some of the new realities we've talked about today.

We have one of the best health systems in the world and it must be protected, improved and adapted to all of today's realities. It must not be destroyed.

In Canada, health care has taken centre stage up to now, consuming the greatest portion of our health dollar. We spent \$66.8 billion on health in 1991. That's \$183 million every day. \$7.6 million every hour!

Next to the U.S., our system is the most expensive health care system in the world. And it's the most expensive publicly financed system in the world.

If these dollars were buying us all better health, it would be money well spent. But, in recent years, the returns on our investment have been disappointing.

So it isn't just a question of pumping more money into health care. We **must** learn how to manage our resources more effectively.

We can maintain universality and high standards while we take stock of our resources, explore our alternatives, streamline our management practices and delivery systems.

By doing these things, we fulfil our obligation to all Canadians -- to our parents who built this country, and to our children whose health and well-being will fuel a healthy Canada.

Every province and territory in Canada is taking action, looking for ways to move health care from high-cost institutional settings towards community-oriented services and supports, especially ones that emphasize prevention.

The federal government salutes and supports these efforts, and similar initiatives by other provinces.

The federal government, working with numerous partners, has been active for many years in the areas of disease prevention and health promotion. We have supported many national strategies which address important health issues from a non-health care perspective.

We should continue and even broaden our preventive and promotional action in areas such as tobacco, drugs, heart health, healthy eating and active living -- because these strategies are designed to help Canadians make informed choices by providing them with sound health information, support and opportunities.

We should also continue to empower communities and groups, encouraging citizens to be more involved in their own health.

In the past, the provinces and territories have been major partners in these national initiatives. In their own jurisdictions, they have also been exploring ways to manage health care more effectively, and many promising models are emerging.

Home- and community-based care to ease the pressure on expensive hospital beds. Limits on medical school enrolment. More emphasis on public education and prevention, and on the creation of supportive environments.

The strong message I get when I talk to Canadians is that they want to be knowledgeable participants in their own health and not just passive recipients of health care. They want more control.

But information is only a part of it. Studies have shown that people who feel lonely or isolated may need a doctor's reassurance much more often than someone who is surrounded by a caring network of relatives and friends. This suggests a strong health promotion role for communities and families.

The vulnerability of many older Canadians, children, women, Aboriginal people and persons with disabilities must be addressed -- and not only those aspects which are improved by health care.

Our health care system must remain efficient, responsive and world class. But we cannot keep it so by draining scarce resources away from other important activities that also contribute to health and quality of life.

Many of these activities take place outside the health sector, for example -- improving our educational system.

Make no mistake about it. Our long term well-being as Canadians depends on the economic health of this country. More hospital beds and physicians won't do it. We must invest where we can get results.

There is only so much money in the pot. We also have to finance things like environmental clean-up programs and old-age pensions -- both measures to safeguard the future. Whether or not they and other vital programs will survive may ultimately depend on the health choices we make today.

All of us are part of the solution -- each of us can take action in our own sphere.

Individual action can and does make a difference. But I am not asking Canadians to do it by themselves.

They must be able to count on government and private sector policies to promote healthy, supportive environment.

Health care providers also have a critical role to play. They can help people make good decisions about the treatment and care they need, and lifestyle choices that will improve the quality of their lives.

Many are already talking to their patients about issues such as smoking, and getting regular exercise. Others are thinking more carefully about the treatments they suggest. They want to ensure that these suit both the patient and the circumstances.

A healthy Canada is one in which everyone recognizes that good health is not a given, but rather is something we must strive for and maintain. It means Canadians are given the benefit of good information and a supportive environment to help them in making appropriate decisions about their lifestyles and the use of health services.

**Healthy Canada** -- you'll see it more and more everywhere. You will see it when we talk to teens about smoking and when we provide them with information about alcohol and other drugs.

You'll notice it when we talk to Canadians about feeling good about themselves, eating well and being active.

For us, **Healthy Canada** means managing risks to health, and ensuring that Canadians understand that there is no such thing as zero risk.

Our job is to ensure that they know how to balance risks with benefits -- whether the subject is natural or synthetic chemicals in food, spending time in the sun, or considering a medical procedure.

We want **Healthy Canada** to remind Canadians that there are things we all can do to improve our health. It is a symbol of the responsibilities we have towards one another.

**Healthy Canada** is a call to all of us to be more actively involved in our own health and that of our families and communities. It recognizes that partnerships between governments, the private sector and health organizations are necessary to make this possible.

It has been said that Canada's people are its best resource. I say that Canadians best resource is their health.

In a few weeks I will no longer be Minister of Health. If I can leave one legacy, it would be what **Healthy Canada** represents: an acknowledgement by all Canadians that by working together, Canadians can create a healthy, strong and secure future -- one in which we continue to benefit from, and take pride in, a health care system that ranks among the finest in the world.

Thank you.





Health and Welfare  
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Santé et Bien-être social  
Canada

# Speech / Discours

Speaking notes  
for Benoît Bouchard  
Minister of National Health and Welfare  
and Minister Responsible for the  
Federal Office of Regional Development - Quebec

Presentation of 1993-94 Main Estimates  
to the Standing Committee on Health, Welfare,  
Social Affairs, Seniors and the Status of Women  
Ottawa, May 25, 1993



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Madam Chairman,

I am most pleased to be here, and I appreciate the opportunity to discuss, with you and your colleagues, the 1993-94 Main Estimates for Health and Welfare Canada, and my department's plans for the coming year.

I would like to introduce those at the table with me:

Mr. Jean-Jacques Noreau, Deputy Minister of the department,

Mr. Scott Serson, Associate Deputy Minister, and

Mr. Orvel Marquardt, Director General, Departmental Planning and Financial Administration.

Madam Chairman, since this will be the last time I will appear before this Committee as Minister of Health and Welfare, I would like to take a moment to reflect on the challenges which my department has faced over the last two years, and the progress we have made in resolving some of the health and social welfare issues affecting Canadians.

My department has always been committed to improving the health and social well-being of Canadians. Through our policies, programs and initiatives over the past two years, we have focused on four main areas:

- ◆ a health care system that is flexible, transferable and accessible;
- ◆ a regulatory process that assures Canadians access to safe and effective pharmaceuticals, medical devices and food, whether processed or not;
- ◆ a social network that protects Canada's less-advantaged citizens -- people with disabilities, seniors, AIDS patients, victims of family violence, and
- ◆ a **National Action Plan for Children** called **Brighter Futures**.

In providing for many of the most vital services that Canadians receive from government, my department has tried to make the best use of our resources, explore alternatives, streamline management and improve delivery of services in light of the financial constraints we all share.

I believe that we have met the fiscal challenge of reconciling responsibility for sound management of government resources with a mandate to meet the health needs of Canadians.

Madam Chairman, I would like to begin by reviewing the first of the four areas I outlined at the start -- the health care system.

I firmly believe that we should take pride in, and work to preserve, a health care system that is one of the finest in the world. With this goal in mind, just two weeks ago, my department launched a program called **Healthy Canada**.

**Healthy Canada** is a call to action, inviting all Canadians to become actively involved in health -- the health of themselves, their families, their communities, their nation.

I believe that each of us here -- and all thoughtful Canadians -- recognize that, as individuals, we must all be responsible for our own health.

The **Canada Food Guide** is a major building block in our **Healthy Canada** campaign to encourage people to take responsibility for their own health.

After years of careful research and development, in partnership with many groups across Canada, we recently published and distributed the new Guide.

Our aim is to reach millions of Canadians, especially such groups as parents and teachers, to significantly improve the health of the nation.

Individually, and collectively, we must think and act responsibly. This, and better management, are the practical answers to the financial pressures confronting our present system. The answer to funding problems is not user fees.

As more Canadians recognize the need to take charge of the personal health aspects of their lives, the more our whole health care system will be on a solid foundation.

The demands on hospitals and health professionals will be caused only by those illnesses and ailments that are not preventable, and the costs to us all will be under control.

In spite of budget constraints, we are continuing to implement our **Action Plan on Health and the Environment** in support of the federal Green Plan initiative.

We are also working closely with the Medical Research Council (MRC) which shares my department's concern for health research. Tough decisions should be based on solid accurate information and MRC, through its recently-launched Strategic Plan, will be promoting health research geared to generating this information.

The MRC is broadening its vision to encompass the full range of health research and developing partnerships and alliances with other sectors that will increase knowledge through research. This will improve Canada's competitive position worldwide through the development of new marketable products and biomedical technologies.

If we want to provide a legacy for the next generation, let it be a nation of people who value, promote and take responsibility for their own health.

We are partners in a national strategy to cut down the use of tobacco. The recent *Tobacco Sales to Young Persons Act* raised the legal age for purchasing tobacco to 18, raised substantially the penalties for sale of tobacco to minors, and restricted the location of cigarette vending machines.

We have also made regulatory changes to the *Tobacco Products Control Act* that will make health messages on tobacco packaging stronger and more visible.

Recently, in collaboration with partners, we launched the **Quit 4 Life** program, a national quit smoking program for teenagers between the ages of 15 and 19.

The program is achieving growing impact with an age group vital to the future success of our campaign against tobacco.

**Canada's Drug Strategy**, a \$210 million program, has entered Phase Two, a new five-year program to combat the abuse of alcohol and other drugs, especially among the young. The heart of our strategy is prevention, and new target groups include those hard to reach, such as children at risk and youngsters living on the street.

We plan to introduce a new **National Pharmaceutical Strategy**, in conjunction with the purchasers -- federal and provincial agencies; the consumers; the suppliers -- and the pharmaceutical industry and the research community.

Our goal is to design and implement an effective strategy which provides optimum benefits at reasonable cost.

The second challenge which I mentioned was a thorough review of the department's regulatory processes.

Dr. Denis Gagnon submitted a report on the *Drug Evaluation Process* with the department. Using Dr. Gagnon's report as the vehicle, we have begun addressing how we do business in the area of drug review and evaluation.

In addition, my department worked with Mr. Ambrose Hearn and a committee of experts including medical, dental, health care, consumer and industry representatives, to review the **Medical Devices Program** and identify the activities necessary to improve that evaluation process.

This has been undertaken within the context of a *major regulatory review*. The first phase of this review, together with the Hearn and Gagnon initiatives, have helped us to develop implementation strategies which, in turn, will allow us to find new ways of regulating health in the best interest of Canadians as we move into the 21st century.

The third focus of our efforts has been the social system. My department's concern for Canadians who are disadvantaged or at risk is reflected in a variety of social welfare initiatives.

The **Child Tax Benefit**, which consolidates existing benefits into a program which is fairer, simpler and incorporates a new supplement for low-income families. The **Child Tax Benefit** provides an additional \$400 million a year for poor working families with children.

It should be noted that, while sunsetting initiatives for the **AIDS** and **Seniors** strategies show a year-over-year decrease of \$52 million, both of these initiatives have been renewed and the 1993-94 Supplementary Estimates will reflect annual funding of \$40 million for **AIDS** and \$27.5 million for **Seniors** initiatives.

The **redesign of Income Security Programs**, to establish a new, streamlined delivery network for our clients, has reached a new phase.

We are going ahead with a proposal to integrate and automate delivery systems for almost three-million Canadians who receive benefits from **Old Age Security** and the **Canada Pension Plan**.

Madam Chairman, I would like to mention another most important program, dealing with a societal problem which has compelled our attention -- family violence.

Over the last two years, the department has greatly increased its activities and role in preventing family violence.

The department will promote employee assistance programs which help prevent abuse and are able to put people back to work.

Through the **Family Violence Initiative**, the department is mobilizing into action everyone -- educators, researchers, health and social work professionals; women's groups, religious leaders, volunteers; business men and women; leaders in Indian, Inuit and Metis communities; representatives of persons with disabilities; and officials from all levels of government and the criminal justice system.

The Government has allocated \$136 million, over four years, to seven departments and agencies, to work in partnerships and to eradicate a scourge which has, in the past, largely been ignored.

And prominent among the victims are children.



The department has sponsored hundreds of projects to ensure that Canadians, recognize, understand and act to prevent family violence.

One recent example, among the many, is a new resource kit, aimed at educating everyone, called *The Mountain and Beyond*.

As we can all realize, there indeed has been a mountain of neglect, misunderstanding and indifference.

Through the efforts of our department -- and our many partners, coast-to-coast -- we are climbing over the mountain, and can see beyond. Beyond will be better informed, more alert and more responsive professionals -- and everyone in the community -- who see the problem, know what to do, and will do it.

Finally, Madam Chairman, I would like to highlight my department's ongoing efforts to improve the lives of Canadian children.

Last year we launched **Brighter Futures**, our response to the fact that many Canadian children live in a state of poverty, unhealthy living conditions, neglect or abuse.

This program is built on four components -- the ratification of the **United Nations Convention on the Rights of the Child**, the implementation of the **Child Tax Benefit**, an **Action Plan for Children**, and the **Child Development Initiative**.

Thus far, we have ratified the **U.N. Convention**, the **Child Tax Benefit** came into effect in January, and the **Action Plan** and **Child Development Initiative** are currently under way.

The **Child Development Initiative** has pledged \$500 million over five years for a series of long-term programs aimed at reducing risks during the earliest years.

The four elements are prevention of illness and injury, protection from abuse, promotion of care and nurturing, and community action ---support for local programs which respond to the health and social needs of children.

Last month we signed a Memorandum of Understanding with the province of Nova Scotia followed by a similar protocol with the province of Quebec two weeks ago. I expect that the other provinces and territories will soon follow.

Although I have referred to my department's success in meeting the four challenges of **Healthy Canada**, regulatory review, protecting the disadvantaged, and **Brighter Futures**, there remains much work to be done.

While focusing on health-related programs, my department has also been reviewing the existing social policy framework.

New directions in social policy, which emphasize prevention, integration of policies and services, and assisting people to achieve greater self-reliance; health policies which emphasize prevention, promotion and early intervention; new directions in fitness and sport; women's health issues; environmental health issues; seniors' programs; prevention and treatment of AIDS; and prevention of substance abuse.

Within the broader context of social policy reform, we must continue to improve our existing health policy. In partnership with the provinces and non-government organizations, we need to pursue changes in such areas as financing, management of physician resources and quality of health care. Together, we must seek to balance quality health care with our available resources.

The initial groundwork we have undertaken and the concerns that have been raised provide the basic framework for a major review of Canada's social policy.

It is this initiative that I will pass on to my successor along with the other programs we have brought forward.

Madam Chairman, I believe everyone who has contributed to the efforts of Health and Welfare Canada can enjoy a sense of achievement -- a job well done -- and be confident that even greater achievements lie ahead.

We shall be glad to answer your questions.

Thank you.





Health and Welfare  
Canada

Santé et Bien-être social  
Canada

# Speech / Discours

**Speaking Notes**

**for**

**The Honourable Mary Collins**

**Minister of Health**

**and**

**Minister responsible for The Status of Women**

**CANADIAN MEDICAL ASSOCIATION**

**Calgary, Alberta**

**August 23, 1993**



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**28/93**

**Canada**



Last week, in Kitchener, Prime Minister Campbell addressed the problems of Canada's educational system - problems that have often been equated in scope to the problems in Canada's health care system. Her message was clear - and constitutionally correct - that **"fully mindful of the rights and the roles of others - in government and outside - Canada's national government will act where it must, lead where it can, and help build consensus where it should."**

That is the same message that I want to bring to this convention and to the millions of Canadians who depend upon your knowledge, your skills, and your example.

Prime Minister Campbell in that same speech in Kitchener made another point that is no less important to this audience and to the people you serve. In speaking of "the Canadian dream", she said:

**"We constructed a network of social programs, believing that health care and education and dignity should come from being Canadian, not from being rich."**

So let me reiterate what both the Prime Minister and I have said with regard to Health Care: this government, that this Prime Minister, that this Minister have no intention of opening up the Canada Health Act to user fees. That means no user fees for medically necessary insured services.

And this is not a policy that is born out of dogma or inflexibility; but rather a position that is upheld by all available evidence. User fees do not cut down on unnecessary demands for services; they merely establish a new division - those who can afford to pay and those who cannot.

Our commitment to the accessibility provision of the Canada Health Act is as firm as our commitment to the other four governing principles - comprehensiveness, universality, portability, and public administration.

With the Canada Health Act as a framework, I do believe we should examine some of Canadians' other concerns such as effectiveness and appropriateness of services. And how about affordability?

I can understand why people need reassurance as governments at all levels and individuals across this country continue to deal with the dilemma of having to do more with the same resources.

Let me make two important statements in answering these concerns.

First, Canadians can rest assured that Canada's health care system is not on the verge of a breakdown as some people would have us believe.

Second, Canada's health care system remains the finest in the world - copied by some, envied by all.

I think that it is time that we really started to separate out problems that are endemic to all governments, to the full range of public services, from those that are unique to the health care system.

Yes, there are too few dollars to provide all the services that the public demands. We must deal with it on a government-wide basis, not merely by focusing on health or education or the environment.

Having said that, however, we, in our sector, must have a plan for dealing with the new reality of the 1990's.

Where do we start? Clearly the status quo is not sustainable.

First, we must have a common goal - and, for me, the highest priority should be directed at improving the health of Canadians in the broadest sense so that they can lead full and fulfilling lives.

Fundamental to achieving that goal is maintaining the integrity of the health care system - and I have already affirmed our continued commitment to the Canada Health Act and its principles.

But I also believe that it means not allowing our national health system to be fragmented into a dozen different systems. While different needs and concerns naturally govern the approaches taken by various provinces and territories, I am sure we all agree that Canadians across this country should have equal access to quality health care.

This means maintaining our commitment to the system which, in 1991, stood at \$66 billion, that's \$2,500 per Canadian, per year or roughly 10% of our gross domestic product. On that basis, Canada ranks second only to the United States, and ahead of any other industrialized nation with a public health insurance system.

Can we get better value for our money from Canada's health system? The answer to this question is neither "yes" or "no", but rather "we must".

Taxpayers are already strained to the limits, but there is not a health system in the world that isn't under pressure, whether from new technologies, new diseases, or the need to meet the challenge of changing demographics. The good news for Canada is that, contrary to popular belief, health care costs are not spiralling out of control. Not that this gives us the right to be complacent.

So the real question is "how". How do we maintain the system which has become the envy of the world?

I do not pretend after less than two months on the job to have all the answers to that question. But I do have a pretty good idea of where to find them - starting right in this room, with you, the physicians, and with other front-line workers. I want to work closely with Canada's medical professionals to find answers to some of the key questions such as:

- ◆ Are there better ways to utilize all of our health resources?
- ◆ Are there alternate settings where quality health care can be provided as well or better? How can we encourage consumers to use them?
- ◆ How can other health care practitioners complement the roles of doctors, and vice versa?
- ◆ Can we develop a national approach to manage physician supply and distribution consistent with our future needs?
- ◆ Can we develop a national consensus on a definition of "medically necessary" that forms the basis of insured services?
- ◆ How can we use new technologies to improve the management and reduce costs of the health care system? Are "smart cards" the way of the future?
- ◆ Can diagnostics, drugs and other remedies be used more effectively?
- ◆ How can we continue to improve public health education?

These are difficult questions and working together as a team with you, our provincial colleagues, and the public is the only way to find sensible and supportable answers.

We are going to need generous doses of both creativity and common sense, but there are already many Canadian success stories to build upon.

From a program standpoint, I think, for example, of the Local Community Service Centres, known as CLSCs in Québec, as a means of providing regionalized health care in a new, cost-effective manner.



I think of my home province, British Columbia's "Quick Response Program" as a community-based solution for emergency institutional care.

And I think of the "Extra-mural" strategy in New Brunswick that contains costs by providing active treatment in-home care.

All of these innovations responded to specific needs in each region while maintaining a commitment to our national principles.

But following the philosophy of "Physician, heal thyself", there is another area that can and must show promise and that is in the area of individuals taking responsibility for their own well-being - not in terms of diagnosis and treatment, but in terms of prevention.

We must distinguish between health care and health. Health involves having the social support of family and friends and living in a safe clean environment - one in which healthy choices are encouraged and made easier.

Individuals must keep fit, reduce personal risks, and take care of their emotional as well as their physical well-being. This may not always be possible, but Canadians should at least be aware of the costs and the consequences of their actions.

There is evidence that Canadians are recognizing the connection between healthy and happier lives - and the proof is in the progress. Canadians are smoking less, paying more attention to what they eat, and exercising more.

While I am encouraged by these improvements, I want to go even further and move much faster in this direction. I want a greater emphasis on disease prevention, health protection, health promotion and education to improve the health status of Canadians as "whole persons" -- physical, mental, emotional and spiritual beings.

Historically, the medical profession has always had an especially important part to play in helping patients recognize and understand what motivates people to make and maintain comprehensive lifestyle changes that lead to fuller and more satisfying lives.

Your efforts already have added enormously to our understanding of the problems and serve as a source of potential solutions.

The Canadian Medical Association (CMA) has been a major partner in a wide spectrum of ground-breaking initiatives ranging from Quality in Health Care and Enhancing Preventive Practices of Health Professionals, to the development of Clinical Practice Guidelines for Physicians. Nor should we forget the Gender-issue Committee of the CMA. Your participation in these important initiative contributes to the renewal of Canada's health system.

I would like to emphasize two other key activities to which the CMA has made important contributions, which relate to my personal priorities as Minister of Health and Minister responsible for the Status of Women, the Interdisciplinary Project on Domestic Violence, which produced an invaluable educational resource kit, and the Reports on Wife Assault.

We must fundamentally change the way we perceive and respond to the problems of physical, psychological and sexual abuse. Though first brought forward by women, this is more than a women's issue -- it is a societal issue.

We must adopt, as recommended by the Canadian Panel on Violence Against Women, "zero tolerance" policies which affirm that no amount of violence is acceptable. We must all commit to actions which guarantee women's rights to dignity, respect, confidentiality, safety and security.

We must also deal with the primary problems of poverty, and basic inequality, if we are to eliminate many of the root causes that contribute both to abuse and to poor mental and physical health, that too many Canadian women experience generation after generation.

Just last week I announced the creation of a Woman's Health Bureau within my department with an education and advocacy role to ensure that women's health issues and needs are more accurately and appropriately reflected in our health system. I will ask the Bureau to work closely with the CMA and your committees which have been doing some excellent work in this area.

I also applaud the Canadian Medical Association for identifying quality of care as one of the highest priority areas for further development in the 1990's, and I am encouraged that gender sensitivity and patients' rights are recognized as fundamental to quality care.

The relationship between physician and patient has always been a privileged one, and that is why any long-term strategies must have the input and become the shared responsibility of all Canadians - funders, providers, and consumers.

We must turn increasingly to Canadians from all walks of life, to ask them what they think about their health care system and how they would like to revitalize it. We are expanding the concept of "Physician, heal thyself" to all Canadians.

There must be a willingness individually and collectively by Canadians to assume greater responsibility for health and the health care system we cherish. It is a great system. I am challenging you to help me make it better.

Naturally, I welcome on-going discussion with the CMA, the Health Action Lobby (HEAL), and other professional groups as part of a collaborative "no surprises" approach.

I also extend a standing invitation to my provincial and territorial colleagues with whom I will be meeting next month in Edmonton. Theirs is a key role in the process of changing health care and I look forward to exchanging views with them.

I have given you my commitment to oppose user fees and reaffirmed my government's pledge to uphold the guiding principles of the Canada Health Act while we search for new ways to sustain our health system.

I have posed a number of questions for you to consider and promised to work with you and our other health partners to resolve them.

By fostering innovation, encouraging excellence and recognizing outstanding performance, we can make a good health system great. We are building on one of the strongest health care foundations in the world, and together I am confident that we can continue to "heal ourselves" for many generations to come.



Health and Welfare  
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# Speech / Discours

Speaking Notes  
for  
The Honourable Mary Collins  
Minister of Health  
and  
Minister Responsible for the Status of Women

Launch of the Alberta Heart Health Program  
Edmonton, September 17, 1993



31/93

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Thank you, Mr. Quinney, for those warm words of welcome. Good morning to you all.

The launch of the **Alberta Heart Health Program** makes me proud to be Canada's Health Minister. This innovative initiative is a living example of the creative ways Canadians are working together to create a Healthy Canada.

Drawing on our different disciplines and applying our specialized skills, we are conquering cardiovascular disease -- an epidemic that strikes too many of our families and friends.

To further this crucial work, I am pleased to announce a research contribution to the **Alberta Heart Health Program** -- worth \$950,000 over the next five years -- from the National Health Research and Development Program (NHRDP) of my Department.

The research that results from this new federal/provincial partnership will produce tangible benefits for Albertans and all Canadians.

Few issues are as critical to our communities or our country. The heartbeat is the very rhythm of life. As the late Canadian novelist, Laura Salverson, once wrote: "Out of the heart are the issues of life!"

A healthy heart is as essential to our emotional well-being as it is vital to our physical survival. Yet cardiovascular disease continues to cut down Canadians. It costs the economy. It fractures families. It literally and figuratively breaks our hearts.

Canadians increasingly recognize that we must focus more on prevention. We need to look beyond the symptoms to the underlying causes. Heart health has to become a personal and community mission. Each of us can take actions to reduce the risk of cardiovascular disease. All of us are part of the solution.

Much of the credit for this new attitude belongs to projects such as yours. The **Alberta Heart Health Project** develops community health coalitions, encourages the private sector and media to assist in promoting healthier lifestyles, and helps Canadians help themselves to fuller, more fulfilling lives.

Cardiovascular disease prevention is equally important as an instrument for social and economic development -- a means to control health care expenditures and increase efficiencies in the use of existing health resources.

The Alberta project will add enormously to the Canadian Heart Health Initiative. In just five years we have already achieved tremendous progress. We have now compiled the Canadian Heart Health Database, the largest of its kind in the world. The Database is an invaluable national resource for policy development and program evaluation.

We are already proving that prevention works. Canada's latest Health Promotion Survey shows that millions of Canadians report they have stopped smoking, improved their diets, learned to manage stress and generally adopted healthier lifestyles.

Not coincidentally, the Canadian Heart and Stroke Foundation -- an important partner in this initiative -- reports the national death rate from heart disease and stroke has been cut in half over the past two decades, due largely to lifestyle improvements and better treatment.

Every gain made in the area of heart health has a positive spin-off. We know that by preventing cardiovascular disease, we are also reducing the rates of some common types of cancers, lung and liver diseases.

Yet there is still so much more that we can and must do. Because people are our richest resource -- their health our best long-term investment.

Individuals can and do make a difference. Ultimately, the battle against cardiovascular disease will be won on a one-by-one basis. But we should not ask individuals to do it by themselves. Government and private sector policies to promote healthy and supportive environments are indispensable to cardiovascular disease prevention.

We must be sure we extend the benefits of prevention to everyone, especially the most vulnerable. For we know that the prevalence of risk and incidence of disease are significantly higher among the disadvantaged.

Preventive policies should include children, the elderly, Aboriginal people and those with disabilities. I am particularly concerned with women's health, a priority for my Department.

Since becoming Minister of Health, I have created a Women's Health Bureau to coordinate the activities of Health Canada as they relate to women's health and disease.

I am anxious that we assess the effectiveness of health policies to ensure they respond to women's needs and will encourage special initiatives geared toward young women's health.

We know that heart disease in women tends to manifest itself later in life. Perhaps this is the reason much less research has been done on heart-disease prevention in women. Whatever the explanation, we need to redress this lack of scientific information and assure equal access to the benefits of prevention.

That work must begin right here, within this community of policy-makers, health care professionals and committed volunteers. We must build on this new partnership to eradicate heart disease, among all populations, and to encourage heart health.

I applaud Dr. Michel Joffres, Principal Investigator of the **Alberta Heart Health Project**, who is leading a multi-centre research project on the Heart Health Database.

The project covers challenging health promotion and disease prevention issues in rural settings, families and youth. The knowledge you gain from this research will be of tremendous value here in Alberta, across Canada and around the world.

Cardiovascular disease knows no borders. Heart health is a global issue. And Canada, courtesy of initiatives such as this one, is rapidly becoming the world leader in the field.

Last year Canada hosted the International Heart Health Conference in Victoria, British Columbia. The Conference gave us the *Victoria Declaration on Heart Health* -- a policy blueprint for prevention.

This remarkable document makes a powerful point: we already have the scientific know-how and the capacity to virtually eliminate this disease. Yet there is still a gap between our knowledge and our lifestyles.

Ways have to be found to promote community action in the effort to reduce cardiovascular disease. Which is precisely where the **Alberta Heart Health Project** comes in. Albertans and Canadians will be looking to you for new ideas and directions.

In these days of economic constraint it is essential that we select carefully the programs in which we choose to invest. I am convinced that the **Alberta Heart Health Project** promises a very high return.

That is why it is my great pleasure to invite the Alberta Health Minister, Shirley McClellan, to accept this cheque as a first instalment in our investment in a heart healthy Alberta and a Healthy Canada.





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# Speech / Discours

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Speaking Notes  
for  
Diane Marleau  
Minister of Health

National Forum on Breast Cancer  
Montreal, November 14, 1993



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Ladies and Gentlemen, Good Morning.

This is my first major opportunity to speak publicly as Canada's new Minister of Health. I am pleased and privileged that it is at a women's health event.

In fact, I deliberately sought an opportunity such as this because I want to signal very strongly and very clearly my determination to focus on women's health issues, generally, and on breast cancer in particular.

As I speak, a woman somewhere in Canada will receive the news that she has breast cancer.

Virtually every Canadian woman harbours the possibility of being stricken with breast cancer. I am a woman. I too am at risk. This year, some 16,300 Canadian women will learn that they have become part of the statistics -- the one in ten who can expect to develop the disease at some time in her life.

It is for these women that we are gathered here today. Every single one of us, representing every perspective on the breast cancer issue, is dedicated to defeating this disease.

How can we resolve the issue of conflicting information about possible treatments and the nature of preventive action. Often scientific studies seem to arrive at totally contradictory conclusions -- making it all the more difficult for women to come to terms with this disease.

Part of our efforts over the next few days may help us decide how we can address some of this confusion.

Over the recent weeks on the election campaign trail, I repeatedly met women -- many of them living with cancer -- who are concerned about the state of our current health system and its ability to respond to their concerns.

The Government of Canada is fully aware of, and committed to addressing, the fundamental shortcomings of the health system as they pertain to women's health needs. It is why our Investing in People proposals in the Liberal Plan for Canada promises to dedicate funds specifically to improving women's health.

We are especially aware of the urgency of breast cancer and recognize that it must receive more attention. This National Forum on Breast Cancer is an important step in what will become an on-going process. We must move quickly to address the needs of women living with the disease.

I am pleased to note that we are forming *a united front*. This Forum will help focus our collective efforts to develop both short and long-term strategies. Our mission is to transform experience and expertise into empowerment, to convert empathy and compassion into action.

It is essential to find a cure for breast cancer. But cure will always be second best to prevention. My vision as Canada's Health Minister is to prove that, by maximizing the energy in this room, the incidence of breast cancer can be significantly reduced and one day, hopefully, prevented altogether.

There was a time when breast cancer was borne stoically, silently and, largely, in isolation. Although many women were ready to expose its physical and emotional scarring, society seemed unwilling or unable to cope with breast cancer.

Outside physicians' offices and cancer clinics, breast cancer carried a social stigma. It was considered a "women's disease", too delicate to discuss in public.

In the 1990s, we cannot afford archaic attitudes or patronizing practices. The days of denial are over. Breast cancer is no longer just a women's issue -- it is a societal issue. And we are all in this together.

Although not every one will experience the personal trauma of being diagnosed with breast cancer, it is a debilitating disease that damages us all. When half our population is at risk, all of society suffers.

The fact that we are here today is an affirmation that we are determined to bring breast cancer out into the open. Breast cancer must be front and centre on the national health agenda.

This National Forum on Breast Cancer will help us to come up with solutions to the many unanswered questions. If ever there was reason for optimism, it is in the potential power of the people in this room. Through this Forum, we can forge strategic alliances.

This Forum will help us draw together our current knowledge, assess the gaps in our understanding, identify opportunities for further research. It will help to build bridges among women, health care providers and researchers so we can work together toward a common goal -- devising strategies to eventually eradicate breast cancer.

This Forum has the potential to be a major step in a long continuum of progress. The pace of progress has accelerated considerably in the last year, since the **Canadian Breast Cancer Initiative** was launched. The **Initiative** is intended to draw together the best that governments, non-governmental organizations, business, industry, the voluntary sector and the public have to offer.

The research component of this **Initiative** should help to identify and support biomedical, psycho-social and prevention research to solve the mystery of breast cancer.

A call for research proposals was issued in the summer of 1993 to establish the areas of interest in breast cancer research in Canada. The output of this Forum will undoubtedly help shape future research directions.

Likewise, the five **Breast Cancer Information Exchange Pilot Projects** across the country will assist both women at risk and women with breast cancer, along with their families and caregivers. These projects will further strengthen our united efforts as they help people to make informed decisions about prevention, early detection, treatment and all aspects of follow-up care.

Important new directions have also been identified by the four Working Groups established for this Forum: the sub-committees on Prevention and Screening; Research; Support, Advocacy and Networking; and Treatment and Care.

This core group of 150 people has laboured long and hard, doing much of the preliminary work which made this conference possible. I want to thank all of these dedicated individuals for their significant contributions.

We must now build on the benefits of earlier efforts and mobilize Canadians in the on-going fight against breast cancer. Working together, we can continue to strengthen existing partnerships and stimulate the creation of new ones.

It is essential that we fully capitalize on the exceptional opportunity this Forum presents. I encourage you to be frank and forthright in your discussions, to express your concerns and opinions openly and to participate fully in the debate.

Perhaps the most promising dimension of this Forum is the leading role women will play in shaping the breast cancer agenda. For the first time, *women* will have influence in recommending priorities and directions for breast cancer research, prevention, treatment and care, support and advocacy.

Women will only begin to assert control over the factors affecting their health when they become equal participants.

Because it is women, most of all, who must be informed about their options; who must have input into the decisions affecting their health; and who need to have a say about the sorts of social supports they require to meet their requirements and those of their families and friends. Who better can provide insight into approaches that are appropriate and responsive to women's and families' needs?

In closing, I want to pay tribute to the sponsors of the Forum -- the Canadian Cancer Society, the National Cancer Institute of Canada, the Medical Research Council of Canada and the Canadian Breast Cancer Foundation.



The committed women and men in these organizations have consistently demonstrated their devotion to the cause through the research, care and support they provide to breast cancer patients.

We are also indebted to our provincial partners for their outstanding efforts towards breast cancer. I want to acknowledge and express my appreciation for the participation of the provincial and territorial governments in this Forum and the many other co-operative ventures in which they play a part.

I can assure you that the federal government is committed to working closely with all the partners, just as it is determined to help women maintain and advance their health and well-being.

As your new Minister of Health, I will ensure that breast cancer is a priority. My department will continue to provide leadership and support for breast cancer research, education, prevention and control.

As the new Government of Canada, we want a country where we all see ourselves as contributors and participants. We want a country whose people live in hope and dignity, not fear.

Canada is a society of reciprocal obligation, with each of us responsible for each other's well-being. A society of reciprocal obligations is a society that can try new things and take risks, because those risks are shared by us all.

So I challenge each of you over the course of the next few days not to be afraid to take chances. Be daring in your discussions, try on new ideas and approaches.

Pulling together, we can and will find solutions to breast cancer's many unanswered questions. The women of Canada are counting on us. We must not let them down.

Thank you.











